HEALTH PARTNERS PLANS
Phone 215-991-4300 Fax 1-866-240-3712

FAX FORM AND CLINICAL DOCUMENTATION

ANTIDEPRESSANTS, OTHER PRIOR AUTHORIZATION FORM *(form effective 7/15/2024)*

Prior authorization guidelines for **Antidepressants, Other** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at https://www.pa.gov/en/agencies/dhs/resources/for-providers/ma-for-providers/pharmacy-services.html.

☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State License #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	Strength:	Dosage form:	
Dose/directions:		Quantity:	Refills:
Diagnosis *(submit documentation)*:		Dx code (*required*):	
Is the beneficiary currently being treated with the requested medication?	☐Yes – date of last dose: _____ *Submit documentation.* ☐No		

Complete all sections that apply to the beneficiary and this request.
Check all that apply and submit documentation for each item.

INITIAL requests

1. For ZULRESSO (brexanolone) and ZURZUVAE (zuranolone):

☐Is being treated for postpartum depression (PPD) AND:
- ☐Has depression with onset in the 3rd trimester through 4 weeks postpartum.
- ☐Has moderate to severe PPD based on a validated depression rating scale (e.g., PHQ-9/EPDS, HAMD-17).
- ☐Is less than or equal to 12 months postpartum.
- ☐Is not actively psychotic, manic, or hypomanic.
- ☐Is not currently pregnant.

2. For ALL OTHER NON-PREFERRED Antidepressants, Other (except Zulresso and Zurzuvae):

☐Tried and failed or has a contraindication or an intolerance to the preferred Antidepressants, Other that are FDA-approved or medically accepted for the treatment of the beneficiary's diagnosis at maximally tolerated doses for at least 6 weeks. (*Refer to https://papdl.com/preferred-drug-list for a list of preferred Antidepressants, Other.)*

☐Tried and failed or has a contraindication or an intolerance to the Antidepressants, SSRIs that are FDA-approved or medically accepted for the treatment of the beneficiary's diagnosis at maximally tolerated doses for at least 6 weeks.

☐ citalopram (e.g., Celexa)
☐ escitalopram (e.g., Lexapro)
☐ fluoxetine (e.g., Prozac, Sarafem)
☐ fluvoxamine (e.g., Luvox)
☐ paroxetine (e.g., Paxil, Pexeva)
☐ sertraline (e.g., Zoloft)

☐ Tried and failed or has a contraindication or an intolerance to augmentation therapy (e.g., lithium, antipsychotic, stimulant) in combination with an antidepressant that is FDA-approved or medically accepted for the treatment of the beneficiary's diagnosis at maximally tolerated doses for at least 6 weeks.

3. For SPRAVTO (esketamine):

☐ Is prescribed Spravato by or in consultation with a psychiatrist.
☐ Will use Spravato in conjunction with a therapeutic dose of an oral antidepressant.
☐ Does not have severe hepatic impairment (Child-Pugh class C).

RENEWAL requests

1. For SPRAVTO (esketamine):

☐ Is prescribed Spravato by or in consultation with a psychiatrist.
☐ Will use Spravato in conjunction with a therapeutic dose of an oral antidepressant.
☐ Does not have severe hepatic impairment (Child-Pugh class C).
☐ Has documentation of improvement in disease severity since starting treatment.

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO 866-240-3712

Prescriber Signature:	**Date**: