pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

ANTIDEPRESSANTS, SSRIs PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Antidepressants, SSRIs** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

PRIOR AUTHORIZATION REQUEST INFORMATION		**PRESCRIBER INFORMATION**	
☐New request ☐Renewal request	total # of pages: _______	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Non-preferred medication requested:

☐Brisdelle capsule	☐Lexapro tablet	☐Paxil CR tablet	☐sertraline solution
☐Celexa tablet	☐paroxetine CR tablet	☐Pexeva tablet	☐Zoloft solution
☐escitalopram solution	☐paroxetine mesylate capsule	☐Prozac Pulvule	☐Zoloft tablet
☐fluoxetine DR 90mg capsule	☐Paxil suspension	☐Sarafem tablet	☐_______________
☐fluvoxamine ER capsule	☐Paxil tablet		

Strength:	Directions:	Quantity:	Refills:
Diagnosis:		Dx code (required):	

Question	Response	
1. Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred Antidepressants, SSRIs? *Check all that apply.* ☐citalopram tablet or solution ☐escitalopram tablet ☐fluoxetine IR capsule, tablet, or solution ☐fluvoxamine IR tablet ☐paroxetine tablet ☐sertraline tablet	☐Yes ☐No	*Submit documentation of medication regimens tried and treatment response, contraindications, and/or intolerances.*
2. Has the beneficiary taken the requested non-preferred medication within the past 90 days?	☐Yes ☐No	*Submit documentation of drug regimen and clinical response.*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**:

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