

ANTIDEPRESSANTS, OTHER PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Antidepressants, Other** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at <https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx>.

<input type="checkbox"/> New request <input type="checkbox"/> 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:			Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:	

CLINICAL INFORMATION

Non-preferred medication requested:	Strength:	Dosage form:
Dose/directions:	Quantity:	Refills:
Diagnosis (<i>submit documentation</i>):	Dx code (<i>required</i>):	
Has the beneficiary taken the requested non-preferred medication within the past 90 days?	<input type="checkbox"/> Yes <i>Submit documentation.</i> <input type="checkbox"/> No	
Does the beneficiary have a history of trial and failure of or contraindication or intolerance to the preferred Antidepressants, Other taken at maximally tolerated doses for at least 6 weeks? <i>Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred agents in this class.</i>	<input type="checkbox"/> Yes <i>Submit documentation.</i> <input type="checkbox"/> No	
Does the beneficiary have a history of trial and failure, contraindication, or intolerance to any of the SSRI antidepressants taken at maximally tolerated doses for at least 6 weeks? <i>Check all that apply.</i> <input type="checkbox"/> citalopram (e.g., Celexa) <input type="checkbox"/> fluvoxamine (e.g., Luvox) <input type="checkbox"/> escitalopram (e.g., Lexapro) <input type="checkbox"/> paroxetine (e.g., Paxil, Pexeva) <input type="checkbox"/> fluoxetine (e.g., Prozac, Sarafem) <input type="checkbox"/> sertraline (e.g., Zoloft)	<input type="checkbox"/> Yes <i>Submit documentation.</i> <input type="checkbox"/> No	
Does the beneficiary have a history of trial and failure, contraindication, or intolerance to augmentation therapy (e.g., lithium, an antipsychotic, a stimulant agent) in combination with an antidepressant at maximally tolerated doses for at least 6 weeks?	<input type="checkbox"/> Yes <i>Submit documentation.</i> <input type="checkbox"/> No	
<i>For Spravato:</i> Does the beneficiary meet all of the following? <i>Check all that apply.</i> <input type="checkbox"/> Will use Spravato in conjunction with a therapeutic dose of an oral antidepressant <input type="checkbox"/> Does not have severe hepatic impairment (Child-Pugh class C) <input type="checkbox"/> <i>For renewal requests for Spravato:</i> Experienced improvement in disease severity since starting treatment with Spravato	<input type="checkbox"/> Yes <i>Submit documentation.</i> <input type="checkbox"/> No	

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

Prescriber Signature:	Date:
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