

**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>.

<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:			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?	<input type="checkbox"/> Yes – date of last dose: _____ Submit documentation. <input type="checkbox"/> No		

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

**INITIAL requests**

- For ZULRESSO (brexanolone) and ZURZUVAE (zuranolone):**
  - Is being treated for postpartum depression (PPD) AND:
    - Has depression with onset in the 3<sup>rd</sup> 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.
- 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.

- |   |   |
|---|---|
| <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)        |

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 DHS – PHARMACY DIVISION**

Prescriber Signature:

Date:

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