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, 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.

☐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*):
Has the beneficiary taken the requested non-preferred medication within the past 90 days?		☐Yes ☐No *Submit documentation.*
Does the beneficiary have a history of trial and failure of or a contraindication or an intolerance to the **preferred Antidepressants, Other** taken at maximally tolerated doses for at least 6 weeks? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred agents in this class.*		☐Yes ☐No *Submit documentation.*
Does the beneficiary have a history of trial and failure of or a contraindication or an intolerance to any of the **SSRI antidepressants** taken at maximally tolerated doses for at least 6 weeks? *Check all that apply.* ☐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)		☐Yes ☐No *Submit documentation.*
Does the beneficiary have a history of trial and failure of or a contraindication or an 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?		☐Yes ☐No *Submit documentation.*
For Spravato: Does the beneficiary meet all of the following? *Check all that apply.* ☐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) ☐*For renewal requests for Spravato:* Experienced improvement in disease severity since starting treatment with Spravato		☐Yes ☐No *Submit documentation.*

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

Prescriber Signature:	Date: