ANTIDEPRESSANTS, OTHER PRIOR AUTHORIZATION FORM

(form effective 7/15/2024)

Keystone First Community HealthChoices | PERFORMRx℠ Next Generation Pharmacy Benefits

Fax to PerformRx℠ at **1-855-851-4058**, or to speak to a representative call **1-866-907-7088**.

PRIOR AUTHORIZATION REQUEST INFORMATION

☐ New request ☐ Renewal request	Total # of pages:	
Name of office contact:	Contact's phone number:	LTC facility contact/phone:

BENEFICIARY INFORMATION

Beneficiary name:	Beneficiary ID#:	DOB:
Street address:		
Apt #: City/state/zip:	Phone:	

PRESCRIBER INFORMATION

Prescriber name:		
Specialty:	NPI:	State license #:
Street address:		
Suite #: City/state/zip:		
Phone:	Fax:	

CLINICAL INFORMATION

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

INITIAL REQUESTS

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

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.)*

List preferred medications tried:_____

☐ 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.

List preferred medications tried:_____

3. For SPRAVATO (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 SPRAVATO (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

Prescriber signature:	Date: