Prior Authorization Request Form for Antidepressant, Other

FAX this completed form to (844) 205-3386

OR Mail requests to: PA Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720 OR Prior authorization may be completed at https://www.covermymeds.com/main/prior-authorization-forms/

I. PROVIDER INFORMATION	II. MEMBER INFORMATION
Prescriber Name:	Member Name:
Prescriber Specialty:	Identification #:
Office Contact Name:	Group #:
Group Name:	Date of Birth:
Fax #:	Medication Allergies:
Phone #:	

III. DRUG INFORMATION (One drug request per form)

Drug name and strength:	Dosage Interval (sig):	Qty. per Day:

IV. REQUIRED DOCUMENTION *(Detailed medical record documentation demonstrating evidence for each item must be submitted with prior authorization request)*

Specify diagnosis & diagnosis code relevant to this request: Dx/Dx Code: _____

Does the member have a history of contraindication to the prescribed medication? ☐ Yes ☐ No

- ☐ Member has a current history (within past 90 days) of using the prescribed the requested non-preferred antidepressant, since: _____
- ☐ If requesting for daily quantity exceeding daily limit (Refer to https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Quantity-Limits-and-Daily-Dose-Limits.aspx), please provide supporting information: _____

Therapeutic Duplication:

If concurrently prescribed a therapeutic duplicate (i.e. antidepressant different from the agent being requested):

- ☐ Member is transitioned from one antidepressant to another with the intent of discontinuing one of the medications
- ☐ Member has a medical reason for concomitant use of the requested medications that is supported by peer-reviewed literature or national treatment guidelines. Supporting evidence: _____

SUBMIT MEDICAL RECORD INFORMATION FOR EACH APPLICABLE ITEM.

INITIAL REQUESTS:

Documented history of therapeutic failure, contraindication or intolerance to at least 2 of the following for at least 6 weeks: (medication, start date and end date) Preferred medications can be found at https://papdl.com/preferred-drug-list

- ☐ Antidepressant, other: _____
- ☐ Antidepressant, SSRI: _____
- ☐ Augmentation therapy (e.g., lithium, antipsychotic, stimulant) in combination with an antidepressant: _____

INITIAL REQUESTS FOR SPRAVATO:

- ☐ Prescribed by or in consultation with a psychiatrist
- ☐ Prescribed in conjunction with a therapeutic dose of an oral antidepressant: _____
- ☐ Member does not have severe hepatic impairment (Child-Pugh class C)

RENEWAL REQUESTS:

- ☐ Documentation of tolerability and experienced a positive clinical response to requested medication evidenced by:_____

RENEWAL REQUESTS FOR SPRAVATO:

- ☐ Prescribed by or in consultation with a psychiatrist
- ☐ Prescribed in conjunction with a therapeutic dose of an oral antidepressant:_____
- ☐ Member has an improvement in disease severity since initiating Spravato, as evidenced by:_____
- ☐ Member does not have severe hepatic impairment (Child-Pugh class C)

IV. ADDITIONAL RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION :

Appropriate clinical information to support the request on the basis of medical necessity must be submitted.	Provider Signature:	Date:

PA Department will respond via fax or phone within 24 hours.

Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)