ANTIDEPRESSANTS, OTHER PRIOR AUTHORIZATION FORM *(form effective 1/5/2026)*

FAX this completed form to (844) 205-3386
OR Mail requests to: Pharmacy 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/

Prior authorization guidelines for **Antidepressants, Other** and **Quantity Limits/Daily Dose Limits** are available on the PA Health & Wellness website at https://www.pahealthwellness.com/providers/pharmacy.html.

☐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:	
Member name:		City/state/zip:	
Member ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

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

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

INITIAL requests

1. **For 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 Zurzuvae),** the member tried and failed or has a contraindication or an intolerance to at least two of the following taken at maximum tolerated doses for at least six weeks:
   - ☐The preferred Antidepressants, Other (*Refer to https://papdl.com/preferred-drug-list for a list of preferred Antidepressants, Other.)*
   - ☐SSRIs
   - ☐Augmentation therapy (e.g., lithium, antipsychotic, stimulant) in combination with an antidepressant

pa health & wellness

3. **For SPRAVTO (esketamine):**
   - ☐ Is prescribed Spravato by or in consultation with a psychiatrist.
   - ☐ 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.
   - ☐ 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 844-205-3386

Prescriber Signature:	**Date**:

Pharmacy 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.)