



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.covermyeds.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 DOCUMENTATION (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?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Member has a current history (within past 90 days) of using the prescribed the requested non-preferred antidepressant, since: _____			
<input type="checkbox"/> 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):			
<input type="checkbox"/> Member is transitioned from one antidepressant to another with the intent of discontinuing one of the medications			
<input type="checkbox"/> 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			
<input type="checkbox"/> Antidepressant, other: _____			
<input type="checkbox"/> Antidepressant, SSRI: _____			
<input type="checkbox"/> Augmentation therapy (e.g., lithium, antipsychotic, stimulant) in combination with an antidepressant: _____			
INITIAL REQUESTS FOR SPRAVATO:			
<input type="checkbox"/> Prescribed by or in consultation with a psychiatrist			
<input type="checkbox"/> Prescribed in conjunction with a therapeutic dose of an oral antidepressant: _____			
<input type="checkbox"/> 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 :

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