Highmark Wholecare
Pharmacy Division
Phone 800-392-1147 Fax 888-245-2049

Requirements for Prior Authorization of Antidepressants, Other

A. Prescriptions That Require Prior Authorization

Prescriptions for Antidepressants, Other that meet any of the following conditions must be prior authorized:

1. A non-preferred Antidepressant, Other. See the Preferred Drug List (PDL) for the list of preferred Antidepressants, Other at: https://papdl.com/preferred-drug-list.

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for an Antidepressant, Other, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. For a non-preferred Antidepressant, Other, **one** of the following:
    1. Has a current history (within the past 90 days) of being prescribed the same non-preferred Antidepressant, Other (does not apply to non-preferred brands when the therapeutically equivalent generic is preferred or to non-preferred generics when the therapeutically equivalent brand is preferred)
    2. **All** of the following:
        a. At least **two** of the following:
            i. Has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Antidepressants, Other approved or medically accepted for the beneficiary's diagnosis at maximally tolerated doses for a duration of ≥ 6 weeks,
            ii. Has a history of therapeutic failure of or a contraindication or an intolerance to the Antidepressants, SSRIs approved or medically accepted for the beneficiary's diagnosis at maximally tolerated doses for a duration of ≥ 6 weeks,
            iii. Has a history of therapeutic failure of or a contraindication or an intolerance to augmentation therapy (e.g., lithium, antipsychotic, stimulant) in combination with an antidepressant approved or medically accepted for the beneficiary's diagnosis at maximally tolerated doses for a duration of ≥ 6 weeks,
        b. Is prescribed the Antidepressant, Other for the treatment of a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling or a medically accepted indication,
        c. Is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature,
        d. Is prescribed a dose and frequency that are consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature,
        e. Does not have a contraindication to the prescribed medication;

AND

2. For Spravato (esketamine), **all** of the following:

   a. Is prescribed Spravato (esketamine) by or in consultation with a psychiatrist,
   b. Is prescribed Spravato (esketamine) in conjunction with a therapeutic dose of an oral antidepressant,
   c. Is prescribed a dose and duration of therapy that are consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature,
   d. Does not have severe hepatic impairment (Child-Pugh class C);

   NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

FOR RENEWALS OF PRIOR AUTHORIZATION FOR ANTIDEPRESSANTS, OTHER: The determination of medical necessity of a request for renewal of a prior authorization for an Antidepressant, Other that was previously approved will take into account whether the beneficiary:

i. For Spravato (esketamine), **all** of the following:

   1. Is prescribed Spravato (esketamine) by or in consultation with a psychiatrist,
   2. Is prescribed Spravato (esketamine) in conjunction with a therapeutic dose of an oral antidepressant,
   3. Is prescribed a dose and duration of therapy that are consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature,
   4. Has documentation of improvement in disease severity since initiating treatment,
   5. Does not have severe hepatic impairment (Child-Pugh class C);

   NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

C. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for an Antidepressant, Other. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary.

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ANTIDEPRESSANTS, OTHER PRIOR AUTHORIZATION FORM

☐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 TO HIGHMARK WHOLECARE – PHARMACY DIVISION

Prescriber Signature:	**Date**: