

I. Requirements for Prior Authorization of Antidepressants, Other**A. Prescriptions That Require Prior Authorization**

Prescriptions for non-preferred Antidepressants, 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:
 - a. Has a current history (within the past 90 days) of being prescribed the same non-preferred Antidepressant, Other
 - b. **All** of the following:
 - i. At least **two** of the following:
 - a) Has a history of therapeutic failure, contraindication, or intolerance of the preferred Antidepressants, Other approved or medically accepted for the beneficiary's diagnosis at maximally tolerated doses for a duration of ≥ 6 weeks,
 - b) Has a history of therapeutic failure, contraindication, or intolerance of the Antidepressants, SSRIs approved or medically accepted for the beneficiary's diagnosis at maximally tolerated doses for a duration of ≥ 6 weeks,
 - c) Has a history of therapeutic failure, contraindication, or intolerance of 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,
 - ii. 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,
 - iii. Is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature,
 - iv. Is prescribed a dose and frequency that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature,
 - v. Does not have a history of 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. 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:

1. 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. Has documentation of improvement in disease severity since initiating treatment,
 - 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.

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.

ANTIDEPRESSANTS, OTHER PRIOR AUTHORIZATION FORM

<input type="checkbox"/> New request	<input type="checkbox"/> 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:			Suite #:	City/state/zip:
Beneficiary ID#:		DOB:	Phone:	Fax:

CLINICAL INFORMATION

Non-preferred medication requested:	Strength:	Dosage form:
Dose/directions:	Quantity:	Refills:
Diagnosis (<i>submit documentation</i>):	Dx code (<i>required</i>):	
Has the beneficiary taken the requested non-preferred medication within the past 90 days?	<input type="checkbox"/> Yes <i>Submit documentation.</i> <input type="checkbox"/> No	
Does the beneficiary have a history of trial and failure of or contraindication or 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.	<input type="checkbox"/> Yes <i>Submit documentation.</i> <input type="checkbox"/> No	
Does the beneficiary have a history of trial and failure, contraindication, or intolerance to any of the SSRI antidepressants taken at maximally tolerated doses for at least 6 weeks? Check all that apply.	<input type="checkbox"/> Yes <i>Submit documentation.</i> <input type="checkbox"/> No	
<input type="checkbox"/> citalopram (e.g., Celexa) <input type="checkbox"/> fluvoxamine (e.g., Luvox) <input type="checkbox"/> escitalopram (e.g., Lexapro) <input type="checkbox"/> paroxetine (e.g., Paxil, Pexeva) <input type="checkbox"/> fluoxetine (e.g., Prozac, Sarafem) <input type="checkbox"/> sertraline (e.g., Zoloft)		
Does the beneficiary have a history of trial and failure, contraindication, or 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?	<input type="checkbox"/> Yes <i>Submit documentation.</i> <input type="checkbox"/> No	
<i>For Spravato:</i> Does the beneficiary meet all of the following? Check all that apply. <input type="checkbox"/> Will use Spravato in conjunction with a therapeutic dose of an oral antidepressant <input type="checkbox"/> Does not have severe hepatic impairment (Child-Pugh class C) <input type="checkbox"/> <i>For renewal requests for Spravato:</i> Experienced improvement in disease severity since starting treatment with Spravato	<input type="checkbox"/> Yes <i>Submit documentation.</i> <input type="checkbox"/> No	

PLEASE FAX COMPLETED FORM TO GATEWAY – PHARMACY DIVISION

Prescriber Signature:	Date:
-----------------------	-------

Confidentiality Notice: The documents accompanying this telecopy may contain confidential information belonging to the sender. The information is intended only for the use of the individual named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any telecopy is strictly prohibited.