HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Antidepressants - Other

Phone: 215-991-4300 **Fax back to: 866-240-3712**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.

Member Name:	Prescriber Name:	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Member Primary Phone:	NPI:	*PA PROMISe ID:*
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP	*Specialty Pharmacy (if applicable):*	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
Directions:		
Diagnosis Code:	**Diagnosis:**	
HPP's maximum approval time is 12 months but may be less depending on the drug.		

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Is the request for continuation of the Antidepressants, Other agent? If YES, go to 12. If NO, go to 2.

☐ Yes ☐ No

Q2. Is the request for Zurzuvae (zuranolone)? If YES, go to 3. If NO, If NO, go to 7.

☐ Yes ☐ No

Q3. The member is prescribed Zurzuvae (zuranolone) for an indication that is included in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication.

☐ Yes ☐ No

Q4. The member is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature.

☐ Yes ☐ No

Q5. The member is prescribed a dose and duration of therapy that are consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature.

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☐ Yes ☐ No

Q6. For a diagnosis of postpartum depression (PPD), all of the following:

☐ Has depression with onset in the third trimester through four 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;

Q7. For all other non-preferred Antidepressants, the member 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).

☐ Yes ☐ No

Q8. The member meets all of the following:

☐ Is prescribed the Antidepressant, Other for the treatment of a diagnosis that is indicated in the FDA-approved package labeling or a medically accepted indication,
☐ Is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature,
☐ Is prescribed a dose and frequency that are consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature,
☐ Does not have a contraindication to the prescribed drug,

Q9. The member meets at least two of the following:

☐ 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 greater than or equal to six weeks,
☐ 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 greater than or equal to six weeks,

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Member Name:	Prescriber Name:

☐ 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 greater than or equal to six weeks;

Q10. The request is for Spravato (esketamine).

☐ Yes ☐ No

Q11. The member meets all of the following:

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

Q12. For a non-preferred Antidepressant, Other with a therapeutically equivalent brand or generic that is preferred on the PDL, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred therapeutically equivalent brand or generic that would not be expected to occur with the requested drug;

☐ Yes ☐ No

Q13. The request is for Spravato (esketamine). If YES, go to 14.

☐ Yes ☐ No

Q14. The member meets all of the following:

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

Q15. Additional Information:

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Member Name:	Prescriber Name:

Prescriber Signature _____ Date _____

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