

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



**Keystone First**

**PERFORMRx**<sup>SM</sup>  
Next Generation Pharmacy Benefits

Fax to PerformRx<sup>SM</sup> at **1-866-497-1387**, or to speak to a representative call **1-800-588-6767**.

PRIOR AUTHORIZATION REQUEST INFORMATION			
<input type="checkbox"/> New request <input type="checkbox"/> Renewal request		Total # of pages:	
Name of office contact:		Contact's phone number:	LTC facility contact/phone:
BENEFICIARY INFORMATION			
Beneficiary name:		Beneficiary ID#:	DOB:
Street address:			
Apt #:	City/state/zip:		Phone:
PRESCRIBER INFORMATION			
Prescriber name:			
Specialty:		NPI:	State license #:
Street address:			
Suite #:	City/state/zip:		
Phone:		Fax:	
CLINICAL INFORMATION			
<b>Drug requested:</b>			
Strength:		Dosage form:	
Dose and directions:		Quantity:	Refills:
Diagnosis ( <i>submit documentation</i> ):			Dx code ( <i>required</i> ):
Is the beneficiary currently being treated with the requested medication?			<input type="checkbox"/> Yes – <i>date of last dose:</i> <input type="checkbox"/> No <i>Submit documentation.</i>
INITIAL REQUESTS			
<b>Complete all sections that apply to the beneficiary and this request.</b> <b>Check all that apply and <i>submit documentation</i> for each item.</b>			
<b>1. For ZURZUVAE (zuranolone):</b> <input type="checkbox"/> Is being treated for postpartum depression (PPD) AND: <input type="checkbox"/> Has depression with onset in the 3rd trimester through 4 weeks postpartum. <input type="checkbox"/> Has moderate to severe PPD based on a validated depression rating scale (e.g., PHQ-9/EPDS, HAMD-17). <input type="checkbox"/> Is less than or equal to 12 months postpartum. <input type="checkbox"/> Is not actively psychotic, manic, or hypomanic. <input type="checkbox"/> Is not currently pregnant.			
<b>2. For ALL OTHER NON-PREFERRED Antidepressants, Other (except Zurzuva):</b> <input type="checkbox"/> Tried and failed or has a contraindication or an intolerance to the <u>preferred Antidepressants, Other</u> that are FDA-approved or medically accepted for the treatment of the beneficiary's diagnosis at maximally tolerated doses for at least 6 weeks. ( <i>Refer to <a href="https://papdl.com/preferred-drug-list">https://papdl.com/preferred-drug-list</a> for a list of preferred Antidepressants, Other.</i> ) List preferred medications tried: _____ <input type="checkbox"/> Tried and failed or has a contraindication or an intolerance to the <u>Antidepressants, SSRIs</u> that are FDA-approved or medically accepted for the treatment of the beneficiary's diagnosis at maximally tolerated doses for at least 6 weeks. <input type="checkbox"/> citalopram (e.g., Celexa) <input type="checkbox"/> escitalopram (e.g., Lexapro) <input type="checkbox"/> fluoxetine (e.g., Prozac, Sarafem) <input type="checkbox"/> fluvoxamine (e.g., Luvox) <input type="checkbox"/> paroxetine (e.g., Paxil, Pexeva) <input type="checkbox"/> sertraline (e.g., Zoloft) <input type="checkbox"/> Tried and failed or has a contraindication or an intolerance to <u>augmentation therapy</u> (e.g., lithium, antipsychotic, stimulant) <u>in combination with an antidepressant</u> that is FDA-approved or medically accepted for the treatment of the beneficiary's diagnosis at maximally tolerated doses for at least 6 weeks. List preferred medications tried: _____			
<b>3. For SPRAVATO (esketamine):</b> <input type="checkbox"/> Is prescribed Spravato by or in consultation with a psychiatrist. <input type="checkbox"/> Does not have severe hepatic impairment (Child-Pugh class C).			

**RENEWAL REQUESTS**

**1. For SPRAVATO (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**

Prescriber signature:

Date:

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