GHP Family Pharmacy Customer Service
100 N. Academy Ave.
Danville, PA 17822
Tel. • 855•552•6028 PA Relay 711 GeisingerHealthPlan.com

Geisinger

ANTIDEPRESSANTS, OTHER PRIOR AUTHORIZATION FORM *(form effective 01/05/2021)*

Prior authorization guidelines for Antidepressants, Other and Quantity Limits/Daily Dose Limits are available on Geisinger Health Plan's website at https://healthplan.geisinger.org/pharmacy/pharmacy.aspx?strip=true&style=OneGeisinger

☐ New request ☐ Renewal request	Total # pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
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 (*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 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 drugs in each class*	☐ Yes ☐ No *Submit Documentation*	
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.* ☐ 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, 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?	☐ Yes ☐ No *Submit Documentation*	
For Spravato: Does the beneficiary meet all of the following? *Check all that apply.* ☐ 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 submit to PromptPA https://ghp.promptpa.com OR fax to Geisinger Health Plan at 570-271-5610 the completed form with required clinical documentation.

Prescriber Signature:	Date: