Louisiana Medicaid
Depression - Antidepressants (Other)

The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request:

- Prior authorization for non-preferred antidepressants (other) for recipients 7 years of age and older; **OR**
- Clinical authorization for **all** preferred and non-preferred agents for recipients younger than 7 years of age; **OR**
- Clinical authorization for esketamine (Spravato®); **OR**
- Clinical authorization for brexanolone (Zulresso®); **OR**
- Clinical authorization for zuranolone (Zurzuvae™).

Additional Point-of-Sale edits may apply.

By submitting the authorization request, the prescriber attests to the conditions available HERE.

Approval Criteria for Initiation and Continuation of Therapy for Non-Preferred Agents for Recipients 7 Years of Age and Older (EXCEPT Spravato®, Zulresso™ and Zurzuvae™)

- There is no preferred alternative that is the exact same chemical entity, formulation, strength, etc.; **AND**
- Previous use of a preferred product - **ONE** of the following is required:
    - The recipient has had a *treatment failure* with at least one preferred product; **OR**
    - The recipient has had an *intolerable side effect* to at least one preferred product; **OR**
    - The recipient has *documented contraindication(s)* to all of the preferred products that are appropriate for the condition being treated; **OR**
    - There is *no preferred product that is appropriate* to use for the condition being treated; **OR**
    - The recipient is established on the requested medication with positive clinical outcomes**.**

Duration of approval for initiation and continuation of therapy: 12 months

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Approval Criteria for Initiation and Continuation of Therapy for *ALL* Agents (Preferred and Non-Preferred) When Requested for Behavioral Health for Recipients Younger Than 7 Years of Age (EXCEPT Spravato®, Zulresso™ and Zurzuvae™)

- **ONE** of the following is true and is **stated on the request**:
    - The recipient has been treated in the past or is *currently receiving treatment with the requested medication with a positive response to treatment without evidence of adverse effects*, and this information is stated on the request; **OR**
    - The recipient has not previously used this medication; however, the prescriber is citing references supporting the use of the medication for the recipient's age and diagnosis (for example, a peer-reviewed journal article demonstrating the safety and efficacy of the requested medication for the indication); **OR**
    - **ALL** medication options that are appropriate for both the age and diagnosis of this recipient:
        - have been tried, resulting in **EITHER** *treatment failure* **OR** *intolerable side effects;* **OR**

        - have not been tried because of a *documented contraindication to the remaining medication options that are appropriate for the age and condition being treated;* **AND**
- There is no preferred alternative that is the exact same chemical entity, formulation, strength, etc.; **AND**
- Previous use of a preferred product – **ONE** of the following is required:
    - The recipient has had *treatment failure* with at least one preferred product; **OR**
    - The recipient has had an *intolerable side effect* to at least one preferred product; **OR**
    - The recipient has a *documented contraindication* to all of the preferred products that are appropriate for the condition being treated; **OR**
    - There is *no preferred product that is appropriate* to use for the condition being treated; **OR**
    - The recipient is established on the medication with positive clinical outcomes**.**

Duration of approval for initiation and continuation of therapy: 12 months

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Esketamine (Spravato®)

Approval Criteria for Initiation of Therapy

- The r~~R~~ecipient is 18 years of age or older on the date of the request**; AND**
- The r~~R~~ecipient has **ONE** of the following diagnoses:
    - Depression for which **the current depressive episode** has not responded adequately to at least **TWO** different antidepressants of adequate dose and duration (treatment-resistant depression); **OR**
    - Depressive symptoms with major depressive disorder (MDD) with acute suicidal ideation or behavior; **AND**
- For recipients with a diagnosis of MDD, ~~E~~esketamine is being given in conjunction with an oral antidepressant**.**

Approval Criteria for Continuation of Therapy

- Prescriber evaluation of the recipient at the end of the induction phase (week 4 of treatment) shows evidence of therapeutic benefit, and the prescriber **states on the request** that the recipient is established on the medication with evidence of a positive response to therapy.~~; AND~~

Duration of approval for initiation of therapy: 4 weeks
Duration of approval for continuation of therapy: 6 months

Brexanolone (Zulresso®)

Approval Criteria

- The recipient is 15 years of age or older on the date of the request; **AND**
- The recipient has a diagnosis of moderate to severe postpartum depression determined by a standardized screening tool for depression [such as, but not limited to, Edinburgh Postnatal

Depression Scale (EPDS), Patient Health Questionnaire (PHQ-9), Beck Depression Inventory (BDI), Hamilton Depression Rating Scale (HAM-D)]; **AND**

- If the recipient has moderate postpartum depression, **ONE** of the following must be **stated on the request**:
    - The recipient has tried and failed a 4-week trial of an oral antidepressant medication [include medication name along with begin and end dates of treatment]; **OR**
    - Recipient has a documented *adverse reaction*, *intolerance*, or *contraindication* to treatment with an oral antidepressant; **AND**
- The **time period of the onset of postpartum depression symptoms is stated on the request**, and onset of symptoms occurred during the third trimester of pregnancy up to four weeks after delivery (the third trimester is from the beginning of pregnancy week 27 to the end of the pregnancy); **AND**
- The recipient is ≤ 6 months postpartum on the date of the request (**state date of delivery on the request)**; **AND**
- **Both** of the following are true and **stated on the request**:
    - The recipient does not have active psychosis; **AND**
    - The recipient does not have a history of bipolar disorder, schizophrenia, and/or schizoaffective disorder; **AND**
- The prescriber **states on the request** that the recipient has not previously received brexanolone for the postpartum depressive episode from the most recent pregnancy; **AND**
- Brexanolone (Zulresso®) is being prescribed by a psychiatrist **OR** an obstetrician-gynecologist**.**

Duration of approval: 30 days [Only one authorization per pregnancy]

Zuranolone (Zurzuvae™)

Approval Criteria

- The recipient is 18 years of age or older on the date of the request; **AND**
- The recipient has a diagnosis of severe postpartum depression determined by a standardized screening tool for depression [such as, but not limited to, Edinburgh Postnatal Depression Scale (EPDS), Patient Health Questionnaire (PHQ-9), Beck Depression Inventory (BDI), Hamilton Depression Rating Scale (HAM-D)]; **AND**
- The **time period of the onset of postpartum depression symptoms is stated on the request**, and onset of symptoms occurred during the third trimester of pregnancy up to four weeks after delivery (the third trimester is from the beginning of pregnancy week 27 to the end of the pregnancy); **AND**
- The recipient is ≤ 12 months postpartum on the date of the request (**state date of delivery on the request)**; **AND**
- The prescriber **states on the request** that the recipient has not previously received brexanolone or zuranolone for the current postpartum depressive episode; **AND**
- **Both** of the following are true and **stated on the request**:
    - The recipient does not have active psychosis; **AND**
    - The recipient does not have a history of bipolar disorder, schizophrenia, and/or schizoaffective disorder; **AND**
- The requested medication is being prescribed by, or the request states that this medication is being prescribed in consultation with, a psychiatrist or an obstetrician-gynecologist; **AND**

- If request is for a non-preferred agent - **ONE** of the following is required: (See Depression – Antidepressants, Other on the PDL/NPDL for list of preferred agents)
    - The recipient has had a *treatment failure* with at least one preferred product; **OR**
    - The recipient has had an *intolerable side effect* to at least one preferred product; **OR**
    - The recipient has *documented contraindication(s)* to all of the preferred products that are appropriate to use for the condition being treated; **OR**
    - There is *no preferred product that is appropriate* to use for the condition being treated.

Duration of approval: 14 days [Only one authorization per pregnancy]

References

ACOG Committee Opinion No. 757 : Screening for Perinatal Depression. Obstetrics & Gynecology 2018;132(5):e208–e212. https://www.acog.org/-/media/Committee-Opinions/Committee-on-Obstetric-Practice/co757.pdf?dmc=1&ts=20181024T2023437995

Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; https://www.clinicalkey.com/pharmacology/

DiPiro JT, Talbert RL, Yee GC, Matzke GR, Wells BG, Posey L. eds. Pharmacotherapy: A Pathophysiologic Approach, 10e New York, NY: McGraw-Hill; https://accesspharmacy.mhmedical.com/book.aspx?bookid=1861

Spravato (esketamine) [package insert]. Titusville, NJ: Janssen Pharmaceuticals, Inc; January~~October~~ 2025~~3~~. https://www.janssenlabels.com/package-insert/product-monograph/prescribing-information/SPRAVATO-pi.pdf

Stewart CM and Vigod S. Postpartum depression. N Engl J Med. 2016;375:2177-2186. https://www.nejm.org/doi/full/10.1056/NEJMcp1607649?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%3dpubmed

Zulresso (brexanolone) [package insert]. Cambridge, MA: Sage Therapeutics Inc; June 2022. https://assets.sagerx.com/zulresso/prescribing-information.pdf

Zurzuvae (zuranolone) [package insert]. Cambridge, MA: Biogen Inc; November 2023. https://documents.sage-biogen.com/us/zurzuvae/pi.pdf

Revision / Date	Implementation Date
Single PDL Implementation	May 2019
Separated “Select Therapeutic Classes (Established)” into individual therapeutic class documents / November 2019	January 2020
Combined Spravato™ criteria and Zulresso® criteria with Depression - Antidepressants (Other) criteria, formatting changes / June 2020	July 2020
Update Spravato™ criteria to include new diagnosis, formatting changes, updated references, modified to apply new age requirement for behavioral health clinical authorization / August 2020	January 2021
Formatting changes / November 2021	January 2022
Updated age indication for Zulresso®, updated references / June 2022	January 2023
Combined Zurzuvae™ criteria with Depression - Antidepressants (Other) criteria, formatting changes, updated references / May 2024	July 2024
Added criterion for Zurzuvae™ and Zulresso® concerning ‘active psychosis’ and ‘history of other mental disorders’ / November 2024	January 2025
Modified criterion related to ‘adjunct therapy’ for Spravato™, updated references / February 2025	May 2025