TRICARE Prior Authorization Request Form for
gepirone (Exxua)



JOHNS HOPKINS
HEALTH PLANS

7231 Parkway Drive, Suite 100
Hanover, MD 21076

Fax completed form and applicable progress notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Prior authorization does not expire.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Is the patient 18 years of age or older?	☐ **Yes** proceed to question **2**	☐ **No** **STOP** **Coverage not approved**
2. Provider acknowledges that patient and provider have discussed that non-pharmacologic interventions [such as, Cognitive Behavioral Therapy (CBT), sleep hygiene] are encouraged to be used in conjunction with this medication.	☐ **Acknowledged** proceed to question **3**	
3. What is the diagnosis or indication?	☐ Major depressive disorder – Proceed to question **4** ☐ Other diagnosis – **STOP – Coverage not approved**	
4. Does the patient have a contraindication to THREE formulary antidepressant medications? Note: formulary antidepressants include: a) SSRIs (selective serotonin reuptake inhibitors, for example, citalopram, escitalopram, fluoxetine, paroxetine, sertraline) b) SNRIs (serotonin/norepinephrine reuptake inhibitors, for example, venlafaxine, desvenlafaxine, duloxetine) c) mirtazapine d) bupropion e) trazodone immediate release f) nefazodone **AND** g) monoamine oxidase inhibitors (MAOI) h) TCAs (tricyclic antidepressants, for example, amitriptyline, desipramine, imipramine, nortriptyline)	☐ **Yes** **Sign and date below**	☐ **No** Proceed to question **5**

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5. Does the patient have an intolerability to THREE formulary antidepressant medications? Note: formulary antidepressants include: a) SSRIs (selective serotonin reuptake inhibitors, for example, citalopram, escitalopram, fluoxetine, paroxetine, sertraline) b) SNRIs (serotonin/norepinephrine reuptake inhibitors, for example, venlafaxine, desvenlafaxine, duloxetine) c) mirtazapine d) bupropion e) trazodone immediate release f) nefazodone **AND** g) monoamine oxidase inhibitors (MAOI) h) TCAs (tricyclic antidepressants, for example, amitriptyline, desipramine, imipramine, nortriptyline)	☐ **Yes** **Sign and date below**	☐ **No** Proceed to question **6**
6. Has the patient failed a trial of THREE formulary antidepressant medications (note: failure of medication is defined as a minimum treatment duration of 4-6 weeks at maximally tolerated dose)? Note: formulary antidepressants include: a) SSRIs (selective serotonin reuptake inhibitors, for example, citalopram, escitalopram, fluoxetine, paroxetine, sertraline) b) SNRIs (serotonin/norepinephrine reuptake inhibitors, for example, venlafaxine, desvenlafaxine, duloxetine) c) mirtazapine d) bupropion e) trazodone immediate release f) nefazodone **AND** g) monoamine oxidase inhibitors (MAOI) h) TCAs (tricyclic antidepressants, for example, amitriptyline, desipramine, imipramine, nortriptyline)	☐ **Yes** **Sign and date below**	☐ **No** **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____
Prescriber Signature Date

[15 July 2026]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: