UTAH MEDICAID PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Spravato (esketamine)

Member and Medication Information * indicates required field	
*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/ Strength:	
☐ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.	
*Directions for use:	
Provider Information * indicates required field	
*Requesting Provider Name:	*Requesting Prescriber NPI:
Address:	
*Contact Person:	*Office Phone:
*Office Fax:	*Office Email:
Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at **855-828-4992**, to prevent processing delays.	

Criteria for Approval: (*All* of the following criteria must be met):

1. Is the patient 18 years of age or older? ❑ **Yes** ❑ **No**
2. Does the patient have a diagnosis of Major Depressive Disorder (MDD)? ICD-10 _____ ❑ **Yes** ❑ **No**
   And is their MDD characterized by one of the following:
   - ☐ Treatment Resistant Depression (TRD)
   - ☐ Acute suicidal ideation
3. Is the medication being prescribed by one of the following? ❑ **Yes** ❑ **No**
   - ☐ Directly by a Prepaid Mental Health Plan (PMHP) provider or a board certified psychiatric-mental health (PMH) provider, including a psychiatrist or psychiatric mental health nurse practitioner (PMHNP) with prescribing authority.
   - ☐ In consultation with a psychiatrist who has provided a patient-specific signed and dated letter attesting to the necessity of treatment in which it is stated the patient's case has been reviewed, and they are available to discuss the patient's case, if needed.
4. Does the provider attest that the patient is **NOT** being prescribed or utilizing ketamine, verified by reviewing the Controlled Substance Database (CSD), to the best of their knowledge? ❑ **Yes** ❑ **No**
5. Has the provider included a baseline depression assessment score utilizing a validated depression rating scale as listed by the American Psychological Association? ❑ **Yes** ❑ **No**
   (https://www.apa.org/depression-guideline/assessment ; examples include HAM-D, PHQ-9, MADRS, BDI, QIDS)
   - ☐ Name of scale and score, date of assessment: _____
6. Within the last 2 years, has the patient tried and failed at least two antidepressants from at least two different classes at up to maximally indicated doses but no less than commonly recognized minimum therapeutic doses, each used for ≥ 6 weeks, unless clinically significant adverse effects are experienced or all are contraindicated? ❑ **Yes** ❑ **No**

   Antidepressant #1 and dose: _____ Antidepressant #2 and dose: _____
   Dates of use: _____ Dates of use: _____
   Result: _____ Result: _____

7. Within the last 2 years, has the patient tried and failed a combination of an antidepressant and one of the following augmentation agents, used concurrently for ≥ 4 weeks, unless clinically significant adverse effects are experienced or all are contraindicated: second generation antipsychotic, lithium, triiodothyronine, buspirone? ❑ **Yes** ❑ **No**
   Antidepressant agent, dose: _____
   Augmentation agent, dose: _____
   Dates of use: _____ Result: _____
8. Does the requesting prescriber attests that they were the prescriber of the antidepressant trials in Criteria 6 and 7, OR if not, that previous chart notes from previous provider, letter from referring provider, and/or pharmacy claims data has been obtained, verified, and provided? ❑ **Yes** ❑ **No**
9. Provider attests that Spravato will be used in conjunction with an oral antidepressant at up to a maximally indicated dose but no less than the commonly recognized minimum therapeutic dose? ❑ **Yes** ❑ **No**
   ☐ Name of medication and dose: _____
10. Does the provider have a plan to monitor and manage "black box" warnings of sedation, disassociation, abuse/misuse, and suicidal thoughts or behaviors? ❑ **Yes** ❑ **No**
11. Does the provider have a plan to administer the medication in a healthcare setting, under the supervision of a healthcare provider, will observe the patient for at least 2 hours after administration, and will advise not to drive or use heavy machinery for the rest of the day? ❑ **Yes** ❑ **No**

Requested doses: *Medicaid approves specific doses and quantities of medications. Please indicate specific dose:*

Treatment-Resistant Depression (TRD)					
Induction Phase			Maintenance Phase		
	First Dose	Second Dose		Dosing Frequency	Continued Dose
Week 1	*Starting Day 1 Dose:* 56mg	□ 56 mg OR □ 84 mg	Weeks 5 – 8	□ once weekly	□ 56 mg OR □ 84 mg
Week 2	□ 56 mg OR □ 84 mg	□ 56 mg OR □ 84 mg			
Week 3	□ 56 mg OR □ 84 mg	□ 56 mg OR □ 84 mg	Week 9 and after	□ once weekly OR □ every 2 weeks	□ 56 mg OR □ 84 mg
Week 4	□ 56 mg OR □ 84 mg	□ 56 mg OR □ 84 mg			

Major Depressive Disorder (MDD) with acute suicidal ideation or behavior	
□ 84 mg twice per week for 4 weeks	□ 56 mg twice per week for 4 weeks (based on tolerability)

Anticipated treatment start date: _____

Reauthorization Criteria:

1. Has the provider included an updated depression scale assessment scale score utilizing the **same** validated depression rating scale (scale name, score) showing a clinically significant improvement from the baseline score? ❑ **Yes** ❑ **No**
   ☐ Name of scale and score, date of assessment: _____
   ☐ Rationale for prescribing if improvement not noted: _____
2. Is the prescriber a PMHP provider or a board certified psychiatric-mental health (PMH) provider, including a psychiatrist or psychiatric mental health nurse practitioner (PMHNP) with prescribing authority OR did the prescriber consult with a psychiatrist who has provided an updated patient-specific signed and dated letter

attesting to the necessity of treatment in which it is stated the patient's case has been reviewed, and they are available to discuss the patient's case if needed? ❑ **Yes** ❑ **No**

3. Does the provider attest that the patient is **NOT** being prescribed or utilizing ketamine, verified by reviewing the Controlled Substance Database (CSD), to the best of their knowledge? ❑ **Yes** ❑ **No**
4. Has the patient been adherent to an oral antidepressant since previous authorization, verifiable by pharmacy refill data? (Adherence is defined as having no more than a 10 day refill gap.) ❑ **Yes** ❑ **No**
5. Provider attests that Spravato will continue to be used in conjunction with an oral antidepressant at up to a maximally indicated dose but no less than the commonly recognized minimum therapeutic dose?
   ☐ Name of medication and dose: _____ ❑ **Yes** ❑ **No**
6. Requested Spravato dosing for reauthorization: _____

Initial Authorization:

Depressive symptoms observed with MDD and acute suicidal ideation or behavior: Up to one (1) month
Treatment-Resistant Depression: Up to three (3) months

Reauthorization for TRD: Up to six (6) months

PRESCRIBER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_____ _____

Prescriber's Signature Date