PRIOR AUTHORIZATION REQUEST: Spravato (esketamine) nasal spray

Please fax form to Amida Care: 1-646-786-0997

MEMBER INFORMATION	
Name:	Medicaid ID #:
Date of Birth:	Phone #:

PRESCRIBER INFORMATION	
Name:	NPI:
Prescriber Specialty: □ Psychiatrist □ Other (in consultation with psychiatrist, please provide name)_____	
Office Phone #:	Office Fax #:
Address:	
Contact Person:	

MEDICATION REQUEST

☐ **Initial Request (Induction + Maintenance) (8 weeks)** ☐ **Reauthorization Maintenance Request* (24 weeks)**

**Initial and reauthorization requests will require documentation of depression symptoms measured at baseline and after 4-8 weeks of therapy with Spravato by the same rating scale used at baseline e.g. HAMD17, QIDS-C16, MADRS, etc.) **

Dose/Kit	Directions for Use	Quantity	Duration
☐ Spravato 56 mg dose kit ☐ Spravato 84 mg dose kit			

REMS facility medication will be administered:	**REMS facility medication will be dispensed:**
Name of Provider Facility: _____ Address/Phone: _____	Name of Pharmacy: _____ Address/Phone: _____

MEDICAL DIAGNOSIS AND CLINICAL CRITERIA

Please provide labs/documentation required for verification of the following questions:

1. **Primary Diagnoses**	ICD-10 Code(s):

2. **Does member have the following diagnoses?** (Check any that apply)
   - ☐ History of moderate/severe substance use disorder according to DSM-5 criteria within 6 months of screening
   - ☐ Current or prior psychotic disorder or MDD with psychosis, bipolar or related disorders
   - ☐ Suicidal ideation with some intent to act within 1 month prior to screening per provider or (C-SSRS)

3. **Has the member had a trial, failure, and/or contraindication of multiple different antidepressant medications?** ☐ Yes ☐ No
   (see examples below)

- Selective serotonin reuptake inhibitors	- Monoamine oxidase inhibitors	- Antipsychotics
- Serotonin norepinephrine reuptake inhibitors	- Serotonin modulators	- Anticonvulsants
- Mirtazapine	- Bupropion	- Tricyclic antidepressants

Please provide documentation of pharmacologic treatments (medication name, dose, duration, and outcome)

Medication Name and Dose	DURATION/DATES	OUTCOME OF TREATMENT
	/	
	/	
	/	
	/	

Please provide documentation of any non-pharmacologic treatments

PRIOR NON-PHARMACOLOGIC TREATMENT	DURATION/DATES	OUTCOME OF TREATMENT
	/	
	/	
	/	

4. **Will Spravato be used in combination with another oral antidepressant?**
   ☐ Yes (indicate which antidepressant below) ☐ No (provide clinical rationale below for monotherapy)

   _____

5. **Has the patient had a urine toxicology panel status (within 6 months prior to request)?** ☐ Yes ☐ No *(Please provide lab results)*

Please call 646-757-7979 or email pharmacyfax@amidacareny.org M-F, 9:00AM-6:00 PM with questions or additional info. You may also provide us with your contact information and the best time to reach you at the top of this document

_____ _____

Prescriber or Authorized Signature Date