

Spravato® (esketamine) Prior Authorization Form

****Please check the applicable box(es)****

[For major depressive disorder (MDD) with acute suicidal ideation or behavior only]

EMERGENCY FILL

Emergency dose has been dispensed: Quantity dispensed: _____ [# of kits; e.g., (1) 84mg dose = #3 kits]
Date Dispersed: _____ (only 1 emergency dose will be approved)

Member Name: _____ **Date of Birth:** _____ **Member ID#:** _____

Drug Information

Physician billing (HCPCS code: _____) **Pharmacy billing (NDC: _____)**

Dose: _____ **Regimen:** _____ **Start Date:** _____

Billing Provider Information

Provider NPI: _____ **Provider Name:** _____

Provider Phone: _____ **Provider Fax:** _____

Prescriber Information

Prescriber NPI: _____ **Prescriber Name:** _____

Prescriber Phone: _____ **Prescriber Fax:** _____ **Specialty:** _____

Criteria

For Initial Authorization [or continued authorization after 1 emergency dose for MDD with acute suicidal ideation or behavior (authorization of 1 emergency dose does not guarantee authorization of further doses)]:

1. Please indicate the diagnosis:
 - Depressive Symptoms in Adults with MDD with Acute Suicidal Ideation or Behavior**
 - Treatment-Resistant Depression**
 - Other:** _____
2. For a diagnosis of depressive symptoms in adults with MDD with acute suicidal ideation or behavior, will Spravato® be used in conjunction with an oral antidepressant? Yes ___ No ___
 - a. If yes, please list the oral antidepressant: _____
3. Will member be monitored by a health care provider for at least 2 hours after each administration? Yes ___ No ___
4. Will the member's blood pressure be monitored prior to and after administration of Spravato® in accordance with the Spravato® *Prescribing Information*? Yes ___ No ___
5. Does the member have any contraindications to therapy [i.e., aneurysmal vascular disease (including thoracic and abdominal aorta, intracranial and peripheral arterial vessels) or arteriovenous malformation; intracerebral hemorrhage; hypersensitivity to esketamine, ketamine, or any of the excipients]? Yes ___ No ___
6. Does the member have severe hepatic impairment (Child Pugh C)? Yes ___ No ___
7. For female members of reproductive potential, please answer all of the following:
 - a. Is the member currently pregnant? Yes ___ No ___
 - b. Will the member use contraception while receiving treatment with Spravato®? Yes ___ No ___
 - c. Is the member breastfeeding? Yes ___ No ___

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PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization Unit

Fax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4

CONFIDENTIALITY NOTICE

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Spravato[®] (esketamine) Prior Authorization Form**Member Name:** _____ **Date of Birth:** _____ **Member ID#:** _____**Criteria****For Initial Authorization:** *(continued)*

8. Are the pharmacy and health care setting certified in the Spravato[®] Risk Evaluation and Mitigation Strategy (REMS) program? Yes ___ No ___
9. Is the member enrolled in the Spravato[®] REMS program? Yes ___ No ___
10. Will Spravato[®] be administered under the direct observation of a health care provider in a REMS certified health care setting? Yes ___ No ___
11. If diagnosis is **Depressive Symptoms in Adults with MDD with Acute Suicidal Ideation or Behavior**, please provide the following (Approvals will be for 4 weeks including doses received while hospitalized, if applicable):
- a. If hospitalized, please provide the number of doses the member received while hospitalized: _____
 - b. Date(s) dose(s) received: _____
12. If diagnosis is **Treatment-Resistant Depression**, please provide the following (Initial approvals will be for the duration of induction phase only):
- a. Has the member had an inadequate response to at least 2 different antidepressants from different classes at least 4 weeks in duration each and titrated to recommended dosing during the current depressive episode? Yes ___ No ___
 - i. If yes, please provide the antidepressant trial information:

Medication: _____ Dose: _____ Dates of Use: _____

Medication: _____ Dose: _____ Dates of Use: _____

- ii. If no, please provide contraindication(s) or clinically-significant adverse effect(s): _____

For Continued Authorization:

1. For **Depressive Symptoms in Adults with MDD with Acute Suicidal Ideation or Behavior**, has member demonstrated an adequate response during the initial 4 weeks of Spravato[®] treatment? Yes ___ No ___
- a. Please provide patient-specific, clinically significant information to support continued use of Spravato[®]:

 - b. Is member using Spravato[®] in combination with an oral antidepressant? Yes ___ No ___
 - i. If yes, please list the oral antidepressant: _____
2. For **Treatment-Resistant Depression**, has member demonstrated an adequate response during the Spravato[®] induction phase? Yes ___ No ___

(Page 2 of 2)**Prescriber Signature:** _____ **Date:** _____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge. Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.

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