Spravato® Prior Authorization Form

Office of Pharmacy Services

Fax#: (866) 440-9345 | Phone#: (800) 932-3918

Patient Information:

Name: _____ DOB: _____

Maryland Medicaid Number: _____

Psychiatrist Information:

Name: _____ NPI#: _____

Phone#: _____ Fax#: _____

Pharmacy Information: *(please provide contact to the Specialty Pharmacy to assure proper billing and prompt patient care)*

Pharmacy Name: _____ Phone#: _____

❑ **Diagnosis: Treatment Resistant Major Depressive Disorder (TRMDD)**

Quantity Limit: Induction – 8 dose kits/28 days; Maintenance – 4 dose kits/ 28 days; (each kit contains 2 or 3 devices)

Approval Duration: Induction – four (4) weeks; Maintenance – six (6) months

Must use in conjunction with an oral antidepressant. **Oral antidepressant and dose**: _____

❑ Patient demonstrated inadequate response to at least <u>two</u> different preferred oral-antidepressant treatments taken at adequate dosage and for adequate duration of at least 42 days.

Adequate trial medication 1: name and dose: _____ Dates: _____

Adequate trial medication 2: name and dose: _____ Dates: _____

Diagnosis: Treatment Resistant Depression				Maximum dose billable by pharmacy	
Induction Phase		**Weeks 1-4**	**Day Supply**	**Weekly**	**Daily**
❑	Spravato 56 mg^ + 84 mg*	56 mg one time + 84 mg one time	_____	5 units/7 days	0.72 units
❑	Spravato 56 mg dose kit^	56 mg (twice a week)	_____	4 units/7 days	0.58 units
❑	Spravato 84 mg dose kit^	84 mg (twice a week)	_____	6 units/7 days	0.86 units
Maintenance Phase		**Weeks 5 and on**	**Day Supply**		
Weekly					
❑	Spravato 56 mg dose kit^	56 mg/7 days	_____	2 units/7 days	0.29 units
❑	Spravato 84 mg dose kit*	84 mg/7 days	_____	3 units/7 days	0.43 units
Every other week					
❑	Spravato 56 mg dose kit^	56 mg/14 days	_____	2 units/14 days	0.15 units
❑	Spravato 84 mg dose kit*	84 mg/14 days	_____	3 units/14days	0.22 units

^Spravato 56 mg dose kit (2x28 mg devices) = 2 units **Spravato 84 mg dose kit (3x28 mg devices) = 3 units*

❑ **Diagnosis: Major Depressive Disorder (MDD) with Acute Suicidal Ideation or behavior**

Quantity Limit: Induction – 8 dose kits/28 days (each kit contains 2 or 3 devices)

Approval Duration: One time approval for four (4) weeks

Must use in conjunction with an oral antidepressant. **Oral antidepressant and dose**: _____

❑ Medication was started as an inpatient and therapy will continue for a total of 4 weeks.

How many weeks of therapy were received as an in-patient? **Dates and dose**: _____

Diagnosis: Suicidal Ideation				Maximum dose billable by pharmacy	
Weeks 1-4			**Day supply**	**Weekly**	**Daily**
❑	Spravato 84 mg dose kit*	84 mg (twice a week)	_____	6 units/7days	0.86 units
❑	Spravato 56 mg dose kit^	56 mg (twice a week)	_____	4 units/7 days	0.58 units

^Spravato 56 mg dose kit (2x28 mg devices) = 2 units **Spravato 84 mg dose kit (3x28 mg devices) = 3 units*

❑ I attest that:

1. Patient has no contraindications (aneurysmal vascular disease, history of intracerebral hemorrhage, hypersensitivity to any components of the drug).
2. Benefits of the treatment for this patient outweigh the risks and verify that the information provided on this form is true and accurate to the best of my knowledge.
3. MDH and prescriber acknowledge and agree that this request may be executed by electronic signature, which shall be considered as an original signature for all purposes and shall have the same force and effect as an original signature.

Prescriber's Signature: _____ Date: _____

Fax completed form to (866) 440-9345. Incomplete forms will not be reviewed.