



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 Depression (TRD)

*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*

Patient demonstrated inadequate response to at least two 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 (TRD)			For pharmacy use: Maximum dose billable		
Induction Phase		Weeks 1-4	Day Supply	Weekly	Daily
<input type="checkbox"/>	Spravato 56 mg [^] + 84 mg*	56 mg one time + 84 mg one time	_____	5 units/7 days	0.72 units
<input type="checkbox"/>	Spravato 56 mg dose kit [^]	56 mg (twice a week)	_____	4 units/7 days	0.58 units
<input type="checkbox"/>	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					
<input type="checkbox"/>	Spravato 56 mg dose kit [^]	56 mg/7 days	_____	2 units/7 days	0.29 units
<input type="checkbox"/>	Spravato 84 mg dose kit*	84 mg/7 days	_____	3 units/7 days	0.43 units
Every other week					
<input type="checkbox"/>	Spravato 56 mg dose kit [^]	56 mg/14 days	_____	2 units/14 days	0.15 units
<input type="checkbox"/>	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: Depressive Symptoms of Major Depressive Disorder with Acute Suicidal Ideation or behavior (MDD with SI)

*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 be used 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: MDD with SI			Maximum dose billable by pharmacy		
Weeks 1-4		Day supply	Weekly	Daily	
<input type="checkbox"/>	Spravato 84 mg dose kit*	84 mg (twice a week)	_____	6 units/7days	0.86 units
<input type="checkbox"/>	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.