SENTARA COMMUNITY PLAN
(MEDICAID)

MEDICAL PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-844-305-2331**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization can be delayed**.

Drug Requested: Spravato® (esketamine)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

Quantity Limit:

- Major Depressive Disorder with Acute Suicidal Ideation or Behavior: 8 kits/month; 1 month of treatment
- Treatment-Resistant Depression: 4 kits/month (*induction dose requires 8 kits/month)

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Choose **ONE** of the following applicable diagnoses below**. Provider Please Note:** Any indication that is **NOT** FDA approved will be considered experimental/investigational and **NOT** medically necessary

❑ **Treatment Resistant Depression. ALL the following criteria must be met:**

Length of Authorization: 1 year

❑ Member must be 18 years of age or older

(Continued on next page)

AND

- ❑ Spravato® must be prescribed by or in consultation with a psychiatrist
  - ❑ Provider is a psychiatrist
  - ❑ Consult with psychiatrist (include name/date): _____

AND

- ❑ Member must have a diagnosis of treatment resistant depression (TRD) without psychotic features defined by current DSM criteria made or verified by a psychiatrist
  - ❑ ICD Code/Diagnosis: _____

AND

- ❑ Member must be experiencing moderate to severe symptomology documented by a standardized rating scale that reliably measures depressive symptoms. **A current baseline (within previous 30 days, prior to starting Spravato®) scale with scoring must be attached.**
  - ❑ Scale: _____
  - ❑ Date Administered: _____

AND

- ❑ Member must have experienced clinical failure or intolerance with at least two (2) antidepressant therapies from at least two (2) different drug classes **(verified by pharmacy paid claims and/or chart notes)**
  - Failures must be of adequate dose (maximally tolerated)
  - Failures must be of adequate duration (at least 6 weeks)
  - Adherent fills required (verified by pharmacy claims)
  - Failures must occur during current depressive episode
  - Antidepressant therapy would include any of the following classes:
    - Selective serotonin reuptake inhibitors (e.g., citalopram, fluoxetine, paroxetine, sertraline)
    - Serotonin norepinephrine reuptake inhibitors (e.g., duloxetine, venlafaxine)
    - Bupropion
    - Tricyclic antidepressants (e.g., amitriptyline, clomipramine, nortriptyline)
    - Mirtazapine
    - Monoamine oxidase inhibitors (e.g., selegiline, tranylcypromine)
    - Serotonin modulators (e.g., nefazodone, trazodone)

1. Drug: _____ Dose: _____ Duration: _____
   Reason for Discontinuation: _____
2. Drug: _____ Dose: _____ Duration: _____
   Reason for Discontinuation: _____

AND

(Continued on next page)

- ❑ Member must have experienced clinical failure or intolerance with at least one (1) augmentation therapy (e.g., lithium, liothyronine, antipsychotics or anticonvulsants) **(verified by pharmacy paid claims and/or chart notes)**
  - Failures must be of adequate dose (maximally tolerated)
  - Failures must be of adequate duration (at least 6 weeks)
  - Adherent fills required (verified by pharmacy claims)
  - Failures must occur during current depressive episode

  1. Drug: _____ Dose: _____ Duration: _____

     Reason for Discontinuation: _____

  2. Drug: _____ Dose: _____ Duration: _____

     Reason for Discontinuation: _____

AND

- ❑ Spravato® must be used in combination with a newly initiated daily oral antidepressant that has not been previously tried. **Documentation (pharmacy claims or chart notes) required.**
  - ❑ Drug: _____

AND

- ❑ Member does **NOT** have aneurysmal vascular disease (including thoracic and abdominal aorta, intracranial and peripheral arterial vessels), arteriovenous malformation, or a history of intracerebral hemorrhage

AND

- ❑ Prescriber must have assessed the member's risk for abuse of controlled substances (i.e., review of medical history, review of state prescription monitoring program (PMP))

AND

- ❑ Member must be enrolled in the Spravato® REMS program

AND

- ❑ Administering site/provider must be certified in the Spravato® REMS program:
  - ❑ Name/Location of Administering Provider: _____

❑ **Diagnosis: Major Depressive Disorder with Suicidal Ideation or Behavior**
❑ **Continuation of inpatient Spravato® therapy, ALL the following criteria must be met:**
One-time authorization per episode for remaining doses required for continuation. Maximum allowable duration = 1 month

- ❑ Provider **MUST** submit date of therapy initiation and number of doses administered up to point of request
  - ❑ Date Spravato® therapy initiated: _____
  - ❑ Number of doses administered since initiation: _____

(Continued on next page)

AND

- ❑ Member must be 18 years of age or older

❑ **Diagnosis: Major Depressive Disorder with Suicidal Ideation or Behavior**
❑ **Initiation of outpatient Spravato® therapy, ALL the following criteria must be met:**
One-time authorization per episode for a duration of 1 month, total of 8 kits/month

- ❑ Member must be 18 years of age or older

AND

- ❑ Spravato® must be prescribed by or in consultation with a psychiatrist
  - ❑ Provider is a psychiatrist
  - ❑ Consult with psychiatrist (include name/date): _____

AND

- ❑ Member must have a diagnosis of major depressive disorder with acute suicidal ideation or behavior verified by a psychiatrist.

AND

- ❑ Spravato® must be used in combination with a daily oral antidepressant. Documentation (pharmacy claims or chart notes) required.
  - ❑ Drug: _____

AND

- ❑ Prescriber must have assessed the member's risk for abuse of controlled substances (i.e., review of medical history, review of state prescription monitoring program (PMP))

AND

- ❑ Member must be enrolled in the Spravato® REMS program

AND

- ❑ Administering site/provider must be certified in the Spravato® REMS program:
  - ❑ Name/Location of Administering Provider: _____

Medication being provided by Specialty Pharmacy – Proprium Rx

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.
Previous therapies will be verified through pharmacy paid claims or submitted chart notes.