

# AvMed

## PHARMACY 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 1-305-671-0200.** No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

**Drug Requested: Spravato<sup>®</sup> (esketamine) (J0013)**

**Mark the benefit you would like the PA entered under:**

- Pharmacy Benefit
- Medical Buy and Bill – submit prior authorization request via fax to **1-844-668-1550**

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

Member Name: \_\_\_\_\_

Member AvMed #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Prescriber Name: \_\_\_\_\_

Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Office Contact Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

NPI #: \_\_\_\_\_

**DRUG INFORMATION:** Authorization may be delayed if incomplete.

Drug Name/Form/Strength: \_\_\_\_\_

Dosing Schedule: \_\_\_\_\_ Length of Therapy: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD Code, if applicable: \_\_\_\_\_

Weight (if applicable): \_\_\_\_\_ Date weight obtained: \_\_\_\_\_

### **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. Check box below for the Diagnosis that applies.

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

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

**Reauthorization is NOT required**

- Member must be 18 years of age or older
  - Spravato<sup>®</sup> must be prescribed by **ONE** of the following:
    - Psychiatrist
    - Provider who has consulted with a psychiatrist (include name/date): \_\_\_\_\_
  - 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:** \_\_\_\_\_
  - 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<sup>®</sup>) scale with scoring must be attached.**
    - Scale:** \_\_\_\_\_
    - Date Administered:** \_\_\_\_\_
  - 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:** \_\_\_\_\_

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- 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:** \_\_\_\_\_
- 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
- 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))
- Member must be enrolled in the Spravato<sup>®</sup> REMS program
- Administering site/provider must be certified in the Spravato<sup>®</sup> REMS program:
  - Name/Location of Administering Provider:** \_\_\_\_\_

**Diagnosis: Major Depressive Disorder with Suicidal Ideation or Behavior**

**Continuation of inpatient Spravato<sup>®</sup> 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<sup>®</sup> therapy initiated:** \_\_\_\_\_
  - Number of doses administered since initiation:** \_\_\_\_\_
- Member must be 18 years of age or older

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