HEALTHY U CHIP

PRIOR AUTHORIZATION REQUEST FORM
KETAMINE

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U CHIP Prior Authorization Department at 801-213-1547.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have medical pharmacy prior authorization questions, please call for assistance: 833-981-0212

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred: ☐ ketamine intravenous injection

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
KETAMINE			
1. Does the member have a diagnosis of moderate to severe major depressive disorder?	☐	☐	**Please provide documentation**
2. Is the member taking an antidepressant and will treatment with an antidepressant continue while taking ketamine?	☐	☐	**Please provide documentation**
3. Has the member had an inadequate response to at least an 8-week trial of the maximum tolerated dose of three different classes of antidepressants?	☐	☐	**Please provide documentation**
4. Does the member have a recent history of substance abuse or alcohol use disorder?	☐	☐	
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has member been compliant with their primary antidepressant if applicable?	☐	☐	**Please provide documentation**
3. Does clinical documentation show a continued medical necessity and a positive clinical response?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:
Physician Signature:

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Policy: PHARM-CHIP-M036
Origination Date: 07/01/2024
Reviewed/Revised Date:
Next Review Date:
Current Effective Date: 07/01/2024