REALRx

PRIOR AUTHORIZATION REQUEST FORM
SPRAVATO™

For authorization, please answer each question and fax this form PLUS chart notes back to Real Rx at 385-425-4052.

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

If you have prior authorization questions, please call for assistance 385-425-5094.

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.

Product being requested: ☐ Spravato™ (esketamine)

Dosing/Frequency:_____

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

Questions	Yes	No	Comments/Notes
SPRAVATO™			
1. Is this request for an **expedited** review? By checking the **"Yes"** box to request an expedited review (24 hours), you are certifying that applying the standard review time frame (72 hours) may place the member's life, health, or ability to regain maximum function in serious jeopardy.	☐	☐	
2. Is the member 18 years of age or older?	☐	☐	
3. Does the member have a diagnosis of moderate to severe major depressive disorder?	☐	☐	**Please provide documentation**
4. If the member is prescribed an antidepressant, has the member been complaint?	☐	☐	
5. Has the member had an inadequate response to at least an 8-week trial of the maximum tolerated dose of at least 3 (three) antidepressants, each from a different class?	☐	☐	**Please provide documentation**
6. Has the member had an inadequate response to intravenous ketamine treatment?	☐	☐	**Please provide documentation**
7. Has the member had an inadequate response to electroconvulsive therapy (ECT)?	☐	☐	**Please provide documentation**
8. Does the member have a recent history of substance abuse or alcohol use disorder?	☐	☐	
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	

2. If the member is prescribed an antidepressant, has the member been complaint?	☐	☐	
3. Does clinical documentation show 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-069
Origination Date: 07/19/2019
Reviewed/Revised Date: 01/18/2023
Next Review Date: 01/18/2024
Current Effective Date: 04/01/2023