

**PRIOR AUTHORIZATION REQUEST FORM**  
**KETAMINE**

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

If you have prior authorization questions, please call Advantage U for assistance: 888-605-0858

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
<b>KETAMINE</b>			
1. Does the member have a diagnosis of moderate to severe major depressive disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Is the member taking an antidepressant and will treatment with an antidepressant continue while taking ketamine?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Does the member have a recent history of substance abuse or alcohol use disorder?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>REAUTHORIZATION</b>			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has member been compliant with their primary antidepressant if applicable?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Does clinical documentation show a continued medical necessity and a positive clinical response?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

**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:

Policy: PHARM-MA-M036

Origination Date: 01/01/2022

Reviewed/Revised Date: 09/19/2022

Next Review Date: 09/19/2023

Current Effective Date: 10/01/2022

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