OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare
Spravato® (Esketamine) Prior Authorization Form

****Please check the applicable box(es)****

[For major depressive disorder (MDD) with acute suicidal ideation or behavior only]

❑**EMERGENCY FILL**

❑**Emergency dose has been dispensed:** Quantity dispensed:____ [# of kits; e.g., (1) 84mg dose = #3 kits]
Date Dispensed:_____ (only 1 emergency dose will be approved)

Member Name: _____ ***Date of Birth:***_____ ***Member ID#:***_____

Drug Information

❑**Physician billing (HCPCS code:_____)** ❑**Pharmacy billing (NDC:_____)**

Dose:_____ ***Regimen:***_____ ***Start Date:***_____

Billing Provider Information

Provider NPI:_____ ***Provider Name:***_____

Provider Phone:_____ ***Provider Fax:***_____

Prescriber Information

Prescriber NPI:_____ ***Prescriber Name:***_____

Prescriber Phone:_____ ***Prescriber Fax:***_____ ***Specialty:***_____

Criteria

Page 1 of 2—Please complete and return <u>all</u> pages. *Failure to complete all pages will result in processing delays.*

For Initial Authorization [or continued authorization after 1 emergency dose for MDD with acute suicidal ideation or behavior (authorization of 1 emergency dose does not guarantee authorization of further doses)]:

1. Please indicate diagnosis:
   - ❑ Depressive Symptoms in Adults with MDD with Acute Suicidal Ideation or Behavior
   - ❑ Treatment-Resistant Depression
   - ❑ Other:_____
2. Will Spravato® be used in conjunction with an oral antidepressant? Yes☐ No☐
   a. If yes, please list the oral antidepressant:_____
3. Will member be monitored by a health care provider for at least 2 hours after each administration? Yes☐ No☐
4. Will the member's blood pressure be monitored prior to and after administration of Spravato® in accordance with the Spravato® *Prescribing Information*? Yes☐ No☐
5. Does the member have any contraindications to therapy [i.e., aneurysmal vascular disease (including thoracic and abdominal aorta, intracranial and peripheral arterial vessels) or arteriovenous malformation; intracerebral hemorrhage; hypersensitivity to esketamine, ketamine, or any of the excipients]? Yes☐ No☐
6. Does the member have severe hepatic impairment (Child Pugh C)? Yes☐ No☐
7. For female members of reproductive potential, please answer <u>all</u> of the following:
   a. Is the member currently pregnant? Yes☐ No☐
   b. Will the member use contraception while receiving treatment with Spravato®? Yes☐ No☐
   c. Is the member breastfeeding? Yes☐ No☐
8. Are the pharmacy and health care setting certified in the Spravato® Risk Evaluation and Mitigation Strategy (REMS) program? Yes☐ No☐
9. Is the member enrolled in the Spravato® REMS program? Yes☐ No☐
10. Will Spravato® be administered under the direct observation of a health care provider in a REMS certified health care setting? Yes☐ No☐

<u>PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:</u>	<u>CONFIDENTIALITY NOTICE</u>
University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4	*This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*

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Member Name: _____ ***Date of Birth:***_____ ***Member ID#:***_____

Criteria

Page 2 of 2—Please complete and return all pages. Failure to complete all pages will result in processing delays.

For Initial Authorization, continued:

11. If diagnosis is **Depressive Symptoms in Adults with MDD with Acute Suicidal Ideation or Behavior**, please provide the following (Approvals will be for 4 weeks including doses received while hospitalized, if applicable):
    a. If hospitalized, please provide the number of doses the member received while hospitalized: _____
       Date(s) dose(s) received:_____
12. If diagnosis is **Treatment-Resistant Depression**, please provide the following (Initial approvals will be for the duration of induction phase only):
    a. Has the member had an inadequate response to at least 2 different antidepressants from different classes at least 4 weeks in duration each and titrated to recommended dosing during the current depressive episode? Yes ☐ No ☐
       i. If yes, please provide the antidepressant trial information:

Medication:_____ Dose:_____ Dates of Use:_____

Medication:_____ Dose:_____ Dates of Use:_____

ii. If no, please provide contraindication(s) or clinically-significant adverse effect(s):

_____

For Continued Authorization:

1. For **Depressive Symptoms in Adults with MDD with Acute Suicidal Ideation or Behavior**, has member demonstrated an adequate response during the initial 4 weeks of Spravato® treatment? Yes ☐ No ☐
   a. Please provide patient-specific, clinically significant information to support continued use of Spravato®:

   _____

   _____
   b. Is member using Spravato® in combination with an oral antidepressant? Yes ☐ No ☐
      i. If yes, please list the oral antidepressant:_____
2. For **Treatment-Resistant Depression**, has member demonstrated an adequate response during the Spravato® induction phase? Yes ☐ No ☐
   a. Is member using Spravato® in combination with an oral antidepressant? Yes ☐ No ☐
      i. If yes, please list the oral antidepressant:_____

Prescriber Signature: _____ **Date:** _____

(By signature, the physician confirms the criteria information above is accurate and verifiable in patient records.) *Please do not send in chart notes. Specific information/documentation will be requested if necessary. Failure to complete this form in full will result in processing delays.*

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