



Spravato® Prior Authorization Form

Office of Pharmacy Services

Fax#: (866) 440-9345 | Phone#: (800) 932-3918

Patient's Information:
 Name: _____ DOB: _____
 Maryland Medicaid Number: _____

Psychiatrist's Information:
 Name: _____ NPI#: _____
 Phone#: _____ Fax#: _____

Pharmacy Information: *(please provide contact to the Specialty Pharmacy to assure proper billing and prompt patient care)*
 Pharmacy Name: _____ Phone#: _____

- Diagnosis: Treatment Resistant Depression (TRD)**
Quantity Limit: Induction – 8 dose kits/28 days; Maintenance – 4 dose kits/ 28 days; (each kit contains 2 or 3 devices)
Approval Duration: Induction – four (4) weeks; Maintenance – six (6) months
- The patient has demonstrated inadequate response to at least two (2) different preferred oral-antidepressant treatments taken at adequate dosage and for adequate duration: (Adequate duration defined as a 30-day trial and failure (of each medication).
Adequate trial medication 1 and dose: _____ **Dates:** _____
Adequate trial medication 2 and dose: _____ **Dates:** _____
 - Must use in conjunction with an oral antidepressant. **Oral antidepressant and dose:** _____
 - Provider attest that the patient has no contraindications (aneurysmal vascular disease, history of intracerebral hemorrhage, hypersensitivity to any components of the drug.

Treatment Resistant Depression			Pharmacy Billing	
Induction Phase	Weeks 1-4	Day Supply	Weekly	Daily
<input type="checkbox"/> Spravato 56 mg [^] + 84 mg*	56 mg one time + 84 mg one time	_____	5 units/7 days	0.72 units
<input type="checkbox"/> Spravato 56 mg dose kit [^]	56 mg (twice a week)	_____	4 units/7 days	0.58 units
<input type="checkbox"/> Spravato 84 mg dose kit [^]	84 mg (twice a week)	_____	6 units/7 days	0.86 units
Maintenance Phase	Weeks 5 and on	Day Supply		
Weekly				
<input type="checkbox"/> Spravato 56 mg dose kit [^]	56 mg/7 days	_____	2 units/7 days	0.29 units
<input type="checkbox"/> Spravato 84 mg dose kit*	84 mg/7 days	_____	3 units/7 days	0.43 units
Every Other Week				
<input type="checkbox"/> Spravato 56 mg dose kit [^]	56 mg/14 days	_____	2 units/14 days	0.15 units
<input type="checkbox"/> Spravato 84 mg dose kit*	84 mg/14 days	_____	3 units/14 days	0.22 units

[^]Spravato 56 mg dose kit (2x28 mg devices) = 2 units

*Spravato 84 mg dose kit (3x28 mg devices) = 3 units

- Diagnosis: Major Depressive Disorder (MDD) with Acute Suicidal Ideation**
Quantity Limit: Induction – 8 dose kits/28 days (each kit contains 2 or 3 devices)
Approval Duration: One time approval for four (4) week treatment
- Medication was started as an inpatient and therapy will continue for a total of 4 weeks. How many weeks of therapy were received as an in-patient? **Dates and dose:** _____
 - Must use in conjunction with an oral antidepressant. **Oral antidepressant and dose:** _____
 - Provider attest that the patient has no contraindications (aneurysmal vascular disease, history of intracerebral hemorrhage, hypersensitivity to any components of the drug.

Suicidal Ideation			Pharmacy Billing	
Weeks 1-4		Day Supply	Weekly	Daily
<input type="checkbox"/> Spravato 84 mg dose kit*	84 mg (twice a week)	_____	6 units/7days	0.86 units
<input type="checkbox"/> Spravato 56 mg dose kit [^]	56 mg (twice a week)	_____	4 units/7 days	0.58 units

[^]Spravato 56 mg dose kit (2x28 mg devices) = 2 units

*Spravato 84 mg dose kit (3x28 mg devices) = 3 units

I certify that the benefits of the treatment for this patient outweigh the risks and verify that the information provided on this form is true and accurate to the best of my knowledge.

Prescriber's Signature: _____ **Date:** _____

Fax completed form to (866) 440-9345. Incomplete forms will not be reviewed