OKLAHOMA Health Care Authority

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

SoonerSelect | aetna

****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 all 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 all 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☐

Fax completed prior authorization request form to **888-601-8461** or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at **AetnaBetterHealth.com/Oklahoma.**

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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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