New Hampshire AIDS Drug Assistance Program
Prior Authorization/Non-Preferred Drug Approval Form

Spravato®

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

FIRST NAME:

MEDICAID ID NUMBER:

DATE OF BIRTH: – –

GENDER: ☐ Male ☐ Female

Drug Name:

Strength:

Dosing Directions:

Length of Therapy:

SECTION II: PRESCRIBER INFORMATION

LAST NAME:

FIRST NAME:

SPECIALTY:

NPI NUMBER:

PHONE NUMBER: – –

FAX NUMBER: – –

SECTION III: CLINICAL HISTORY

1. Does the patient have a diagnosis of major depressive disorder (DSM-5)? ☐ Yes ☐ No
2. Has a baseline depression assessment been done using a validated depression rating scale? ☐ Yes ☐ No
3. Is the prescriber a psychiatrist or psychiatric mental health nurse practitioner, or has one of these specialists been consulted? ☐ Yes ☐ No

(Form continued on next page.)

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SECTION III: CLINICAL HISTORY *(CONTINUED)*

4. Does the patient have a diagnosis of aneurysmal vascular disease, arteriovenous malformation, history of intracranial hemorrhage, uncontrolled hypertension, or known hypersensitivity to any component? ☐ Yes ☐ No
5. Is the patient pregnant? ☐ Yes ☐ No
6. Will the patient receive an additional antidepressant medication with Spravato®? ☐ Yes ☐ No
7. Please describe the antidepressant regimen to be used with Spravato®:

8. Do you attest to certification of the healthcare setting in the Spravato® REMS program? ☐ Yes ☐ No
9. Do you attest that the patient's blood pressure will be monitored prior to each administration and at least 2 hours after each administration? ☐ Yes ☐ No
10. Do you attest to reviewing the dosing schedule with the patient and confirmed the patient's understanding and availability of transportation? ☐ Yes ☐ No
11. Is Spravato® being used for treatment-resistant depression for this patient? ☐ Yes ☐ No
12. Has the patient tried psychotherapy? ☐ Yes ☐ No
13. Has the patient tried and failed ketamine for treatment of MDD? ☐ Yes ☐ No
14. Is the patient receiving electroconvulsive therapy (ECT), vagus nerve stimulation (VNS), transcranial magnetic stimulation (TMS), or deep brain stimulation (DBS)? ☐ Yes ☐ No
15. Has the patient tried at least 2 different antidepressants from different classes for at least 6 weeks each? ☐ Yes ☐ No
    a. Please describe treatment failure, contraindications, or significant adverse reactions. **If additional space is needed, please use another page.**

16. Has the patient tried and failed at least 1 antidepressant augmentation therapy for at least 6 weeks? (for example: atypical antipsychotics, lithium, an antidepressant from a different class) ☐ Yes ☐ No
    a. Please describe treatment failure, contraindications, or significant adverse reactions. **If additional space is needed, please use another page.**

(Form continued on next page.)

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PATIENT LAST NAME:	**PATIENT FIRST NAME:**

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

PRESCRIBER'S SIGNATURE: _____ **DATE**: _____

Phone: 1-800-424-7901
Fax: 1-800-424-7984

Effective Date: 08/13/2021

Magellan Rx MANAGEMENT