



**New Hampshire Medicaid Fee-for-Service Program
Prior Authorization/Non-Preferred Drug Approval Form**

Spravato®

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

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FIRST NAME:

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MEDICAID ID NUMBER:

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DATE OF BIRTH:

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GENDER: Male Female

Drug Name:

Strength:

Dosing Directions:

Length of Therapy:

SECTION II: PRESCRIBER INFORMATION

LAST NAME:

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FIRST NAME:

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SPECIALTY:

NPI NUMBER:

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PHONE NUMBER:

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FAX NUMBER:

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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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DATE OF MEDICATION REQUEST: / /

PATIENT LAST NAME:

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PATIENT FIRST NAME:

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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®:
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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.**
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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.)

