Spravato

CareFirst Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical*	❑ *Home*	❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital*	❑ *Office*	❑ *Pharmacy*

What is the ICD-10 code? _____

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

 Spravato SGM 2889-A – 04/2025.

Criteria Questions:

1. What is the diagnosis?

❒ Major Depressive Disorder with acute suicidal ideation or behavior, *Continue to 23*

❒ Treatment-resistant depression (TRD), *Continue to 2*

❒ Other, please specify. _____, *No further questions*

2. Is this a request for continuation of therapy with the requested drug?
❒ Yes, *Continue to 3*
❒ No, *Continue to 7*

3. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 7*

❒ No, *Continue to 4*

❒ Unknown, *Continue to 7*

4. Does the patient have a moderate or severe substance or alcohol use disorder that is currently not being treated or medically managed?
❒ Yes, *Continue to 5*
❒ No, *Continue to 5*

5. Will the requested drug be prescribed by or in consultation with a psychiatrist?
❒ Yes, *Continue to 6*
❒ No, *Continue to 6*

6. Has there been improvement or sustained improvement from baseline in depressive symptoms documented by standardized rating scales that reliably measure depressive symptoms (e.g., Beck Depression Inventory [BDI], Hamilton Depression Rating Scale [HDRS], Montgomery-Asberg Depression Rating Scale [MADRS], etc.)?
ACTION REQUIRED: If Yes, please attach chart note(s) documenting current depression severity score(s) from standardized rating scale(s) that reliably measure depressive symptoms (e.g., Beck Depression Inventory [BDI], Hamilton Depression Rating Scale [HDRS], Montgomery-Asberg Depression Rating Scale [MADRS], etc.).
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

7. Does the patient have a moderate or severe substance or alcohol use disorder that is currently not being treated or medically managed?
❒ Yes, *Continue to 8*
❒ No, *Continue to 8*

8. Will the requested drug be prescribed by or in consultation with a psychiatrist?
❒ Yes, *Continue to 9*
❒ No, *Continue to 9*

9. Does the patient have a confirmed diagnosis of severe major depressive disorder (single or recurrent episode), documented by standardized rating scales that reliably measure depressive symptoms (e.g., Beck Depression Inventory [BDI], Hamilton Depression Rating Scale [HDRS], Montgomery-Asberg Depression Rating Scale [MADRS], etc.)? ***ACTION REQUIRED***: If Yes, attach chart note(s) documenting pretreatment depression severity score(s) from standardized rating scale(s) that reliably measure depressive symptoms (e.g., Beck Depression Inventory [BDI], Hamilton Depression Rating Scale [HDRS], Montgomery-Asberg Depression Rating Scale [MADRS], etc.).
❒ Yes, *Continue to 10*
❒ No, *Continue to 10*

10. What is the patient's age (in years)?

❒ Less than 18 years old, *Continue to 11*

❒ Greater than or equal to 18 years old, *Continue to 11*

11. Will the requested drug be administered under the direct supervision of a healthcare provider?
❒ Yes, *Continue to 12*
❒ No, *Continue to 12*

12. Will the patient be monitored by a health care provider for at least 2 hours after administration?
❒ Yes, *Continue to 13*
❒ No, *Continue to 13*

13. Has the patient experienced an inadequate response with two antidepressants from at least two different classes with different mechanisms of action during the current depressive episode (Note: The current depressive episode begins with the most recent onset of acute symptoms.)? ***ACTION REQUIRED***: If Yes, please attach medical/prescription records or chart note(s) documenting failure with antidepressant agents.
❒ Yes, *Continue to 14*
❒ No, *Continue to 21*

14. Please indicate the therapeutic class for the first antidepressant tried where an inadequate response was experienced during the current depressive episode.

❒ Aminoketone (Wellbutrin/SR/XL [bupropion]), *Continue to 15*
❒ Monoamine oxidase inhibitors (MAOIs) (e.g., Marplan, Nardil, Parnate, phenelzine, tranylcypromine), *Continue to 15*
❒ Noradrenaline and specific serotoninergic antidepressants (NASSAs) (e.g., amoxapine, maprotiline, mirtazapine/ODT, Oleptro ER, Remeron/Solutab, trazodone), *Continue to 15*
❒ Selective serotonin reuptake inhibitors (SSRIs) (e.g., Celexa, citalopram, escitalopram, fluoxetine, fluvoxamine, Lexapro, Luvox/CR, paroxetine, Paxil/CR, Pexeva, Prozac/Weekly, sertraline, Zoloft), *Continue to 15*
❒ Serotonin-norepinephrine reuptake inhibitors (SNRIs) (e.g., Cymbalta, desvenlafaxine/ER, duloxetine, Effexor/XR, Fetzima, Khedezla, Pristiq, venlafaxine/ER), *Continue to 15*
❒ Tricyclic antidepressants (TCAs) (e.g., amitriptyline, desipramine, doxepin, Elavil, imipramine, Norpramin, nortriptyline, Pamelor, Surmontil, Tofranil, trimipramine), *Continue to 15*

❒ Serotonin modulators (e.g., Trintellix, vortioxetine, Viibryd, vilazodone), *Continue to 15*

❒ Other, please specify. _____, *Continue to 15*

15. Was the trial with the first antidepressant at least 8 weeks in duration within the past 5 years?

❒ Yes, please specify trial length (in weeks). _____weeks, *Continue to 16*

❒ No, *Continue to 16*

16. Was the first antidepressant titrated up to the maximally tolerated labeled dose?
❒ Yes, *Continue to 17*
❒ No, *Continue to 21*

17. Please indicate the therapeutic class for the second antidepressant tried where an inadequate response was experienced during the current depressive episode.

❒ Aminoketone (Wellbutrin/SR/XL [bupropion]), *Continue to 18*
❒ Monoamine oxidase inhibitors (MAOIs) (e.g., Marplan, Nardil, Parnate, phenelzine, tranylcypromine), *Continue to 18*
❒ Noradrenaline and specific serotoninergic antidepressants (NASSAs) (e.g., amoxapine, maprotiline, mirtazapine/ODT, Oleptro ER, Remeron/Solutab, trazodone), *Continue to 18*
❒ Selective serotonin reuptake inhibitors (SSRIs) (e.g., Celexa, citalopram, escitalopram, fluoxetine, fluvoxamine, Lexapro, Luvox/CR, paroxetine, Paxil/CR, Pexeva, Prozac/Weekly, sertraline, Zoloft), *Continue to 18*
❒ Serotonin-norepinephrine reuptake inhibitors (SNRIs) (e.g., Cymbalta, desvenlafaxine/ER, duloxetine, Effexor/XR, Fetzima, Khedezla, Pristiq, venlafaxine/ER), *Continue to 18*
❒ Tricyclic antidepressants (TCAs) (e.g., amitriptyline, desipramine, doxepin, Elavil, imipramine, Norpramin, nortriptyline, Pamelor, Surmontil, Tofranil, trimipramine), *Continue to 18*

❒ Serotonin modulators (e.g., Trintellix, vortioxetine, Viibryd, vilazodone), *Continue to 18*

❒ Other, please specify. _____, *Continue to 18*

18. Was the therapeutic class of the second antidepressant tried different from the class of the first antidepressant tried?
❒ Yes, *Continue to 19*
❒ No, *Continue to 21*

19. Was the trial with the second antidepressant at least 8 weeks in duration within the past 5 years?

❒ Yes, please specify trial length (in weeks). _____weeks, *Continue to 20*

❒ No, *Continue to 21*

20. Was the second antidepressant titrated up to the maximally tolerated labeled dose?
❒ Yes, *Continue to 21*
❒ No, *Continue to 21*

21. Has the patient experienced an inadequate response with an adequate trial of evidenced-based psychotherapy (i.e., cognitive behavioral therapy [CBT], interpersonal therapy [IPT], supportive therapy [ST], or psychoeducational intervention [PEI]) during the current depressive episode (Note: The current depressive episode begins with the most recent onset of acute symptoms.)? ***ACTION REQUIRED***: If Yes, please attach medical records or chart note(s) documenting inadequate response to evidence-based psychotherapy.
❒ Yes, *No Further Questions*
❒ No, *Continue to 22*

22. Has the patient experienced an inadequate response with an adequate trial with any of the following augmentation therapies, for at least 8 weeks within the past 5 years during the current depressive episode (Note: The current depressive episode begins with the most recent onset of acute symptoms): a) Two antidepressants with different mechanisms of action used concomitantly, b) An antidepressant and a second-generation antipsychotic used concomitantly, c) An antidepressant and lithium used concomitantly, or d) An antidepressant and thyroid hormone used concomitantly? ***ACTION REQUIRED***: If Yes, please attach medical/prescription records or chart note(s) documenting the length of the trial and failure with augmentation therapies.
❒ Yes, Two antidepressants with different mechanisms of action used concomitantly ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
Length of trial _____Weeks/Months/Years (please select)
❒ Yes, An antidepressant and a second-generation antipsychotic used concomitantly ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
Length of trial _____Weeks/Months/Years (please select)
❒ Yes, An antidepressant and lithium used concomitantly ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
Length of trial _____Weeks/Months/Years (please select)
❒ Yes, An antidepressant and thyroid hormone used concomitantly ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
Length of trial _____Weeks/Months/Years (please select)

❒ No, *No further questions*

23. Does the patient have a moderate or severe substance or alcohol use disorder that is currently not being treated or medically managed?
❒ Yes, *Continue to 24*
❒ No, *Continue to 24*

24. Will the requested drug be prescribed by or in consultation with a psychiatrist?
❒ Yes, *Continue to 25*
❒ No, *Continue to 25*

25. Does the patient have a confirmed diagnosis of severe major depressive disorder (single or recurrent episode), documented by standardized rating scales that reliably measure depressive symptoms (e.g., Beck Depression Inventory [BDI], Hamilton Depression Rating Scale [HDRS], Montgomery-Asberg Depression Rating Scale [MADRS], etc.)? ***ACTION REQUIRED***: If Yes, please attach chart note(s) documenting pretreatment depression severity score(s) from standardized rating scale(s) that reliably measure depressive symptoms (e.g., Beck Depression Inventory [BDI], Hamilton Depression Rating Scale [HDRS], Montgomery-Asberg Depression Rating Scale [MADRS], etc.).
❒ Yes, *Continue to 26*
❒ No, *Continue to 26*

26. What is the patient's age (in years)?

❒ Less than 18 years old, *Continue to 27*

❒ Greater than or equal to 18 years old, *Continue to 27*

27. Will the requested drug be administered under the direct supervision of a healthcare provider?
❒ Yes, *Continue to 28*
❒ No, *Continue to 28*

28. Will the patient be monitored by a health care provider for at least 2 hours after administration?
❒ Yes, *Continue to 29*
❒ No, *Continue to 29*

29. Will the requested drug be used in combination with an oral antidepressant (e.g., duloxetine, escitalopram, sertraline, venlafaxine)?
❒ Yes, *Continue to 30*
❒ No, *Continue to 30*

30. Does the patient have major depressive disorder with current suicidal ideation with intent?
❒ Yes, *Continue to 31*
❒ No, *Continue to 31*

31. Does the patient currently have thoughts, even momentarily, of self-harm with at least some intent or awareness that they may die as a result, or the patient thinks about suicide?
❒ Yes, *Continue to 32*
❒ No, *Continue to 33*

32. Does the patient intend to act on thoughts of killing themselves?
❒ Yes, *Continue to 33*
❒ No, *Continue to 33*

33. Does the prescriber represent that, in the absence of the requested drug, within the next 24 to 48 hours the patient will require confinement in an acute care psychiatric institution?
❒ Yes, *Continue to 34*
❒ No, *Continue to 34*

34. Is this a request for continuation of therapy with the requested drug?
❒ Yes, *Continue to 35*
❒ No, *No Further Questions*

35. Has the patient been treated beyond 4 weeks?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062
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