CAREFIRST COMMERCIAL - NON-RISK - SPC
Spravato SGM

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS Caremark at 866-249-6155. Please contact CVS Caremark at 866-814-5506 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Spravato SGM.

Patient Information

Patient Name:

Patient Phone: ☐☐☐-☐☐☐-☐☐☐☐

Patient ID:

Patient Group:

Patient DOB: ☐☐/☐☐/☐☐☐☐

Physician Information

Physician Name

Physician Phone: ☐☐☐-☐☐☐-☐☐☐☐

Physician Fax: ☐☐☐-☐☐☐-☐☐☐☐

Physician Addr.:

City, St, Zip:

Drug Name (select from list of drugs shown)

Spravato

Quantity: _____ **Frequency:** _____ **Strength:** _____

Route of Administration: _____ **Expected Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

_____

Please check the appropriate answer for each applicable question.

1. What is the diagnosis?

   - ☐ Major Depressive Disorder with acute suicidal ideation or behavior (If checked, go to 24)
   - ☐ Treatment resistant depression (If checked, go to 2)
   - ☐ Other, please specify. (If checked, no further questions) _____

2. Is this a request for continuation of therapy with the requested drug? **Y** ☐ **N** ☐

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

   - ☐ Yes (If checked, go to 7)
   - ☐ No (If checked, go to 4)
   - ☐ Unknown (If checked, go 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? **Y** ☐ **N** ☐

5. Will the requested drug be prescribed by or in consultation with a psychiatrist? **Y** ☐ **N** ☐

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 Scale [BDI], Hamilton Depression Rating Scale [HDRS], Montgomery-Asberg Depression Rating Scale [MADRS], etc.)? ACTION REQUIRED: If Yes, attach chart note(s) documenting current depression severity score(s) from standardized rating scale(s). **Y** ☐ **N** ☐

7. Does the patient have a moderate or severe substance or alcohol use disorder that is currently not being treated or medically managed? **Y** ☐ **N** ☐

8. Will the requested drug be prescribed by or in consultation with a psychiatrist? **Y** ☐ **N** ☐

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 Scale [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). **Y** ☐ **N** ☐

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

    Less than 18 years old (If checked, no further questions) ☐

    Greater than or equal to 18 years old (If checked, go to 11) ☐

11. Will the requested drug be administered under the direct supervision of a healthcare provider? **Y** ☐ **N** ☐

12. Will the patient be monitored by a health care provider for at least 2 hours after administration? **Y** ☐ **N** ☐

13. Will the requested drug be used in combination with an oral antidepressant (e.g., duloxetine, escitalopram, sertraline, venlafaxine)? **Y** ☐ **N** ☐

14. Has the patient experienced an inadequate response with two antidepressants from at least two different classes (with a different mechanism of action) during the current depressive episode? ACTION REQUIRED: Attach medical/prescription records or chart note(s) documenting failure with antidepressant agents. **Y** ☐ **N** ☐

15. 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]) (If checked, go to 16) ☐

    Monoamine oxidase inhibitors (MAOIs) (e.g., Marplan, Nardil, Parnate, phenelzine, tranylcypromine) (If checked, go to 16) ☐

    Noradrenaline and specific serotoninergic antidepressants (NASSAs) (e.g., amoxapine, maprotiline, mirtazapine/ODT, Oleptro ER, Remeron/Solutab, trazodone) (If checked, go to 16) ☐

    Selective serotonin reuptake inhibitors (SSRIs) (e.g., Celexa, citalopram, escitalopram, fluoxetine, fluvoxamine, Lexapro, Luvox/CR, paroxetine, Paxil/CR, Pexeva, Prozac/Weekly, sertraline, Zoloft) (If checked, go to 16) ☐

    Serotonin-norepinephrine reuptake inhibitors (SNRIs) (e.g., Cymbalta, desvenlafaxine/ER, duloxetine, Effexor/XR, Fetzima, Irenka, Khedezla, Pristiq, venlafaxine/ER) (If checked, go to 16) ☐

    Tricyclic antidepressants (TCAs) (e.g., amitriptyline, desipramine, doxepin, Elavil, imipramine, Norpramin, nortriptyline, Pamelor, Surmontil, Tofranil, trimipramine) (If checked, go to 16) ☐

    Serotonin modulators (e.g., Trintellix, vortioxetine, Viibryd, vilazodone) (If checked, go to 16) ☐

    Other, please specify. (If checked, no further questions) _____

16. Was the trial with the first antidepressant at least 8 weeks in duration?

    Yes, please specify trial length (in weeks). (If checked, go to 17) _____

    No (If checked, no further questions) ☐

17. Was the first antidepressant titrated up to the maximally tolerated labeled dose? **Y** ☐ **N** ☐

18. 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]) (If checked, go to 19) ☐

Monoamine oxidase inhibitors (MAOIs) (e.g., Marplan, Nardil, Parnate, phenelzine, tranylcypromine) (If checked, go to 19) ☐

Noradrenaline and specific serotoninergic antidepressants (NASSAs) (e.g., amoxapine, maprotiline, mirtazapine/ODT, Oleptro ER, Remeron/Solutab, trazodone) (If checked, go to 19) ☐

Selective serotonin reuptake inhibitors (SSRIs) (e.g., Celexa, citalopram, escitalopram, fluoxetine, fluvoxamine, Lexapro, Luvox/CR, paroxetine, Paxil/CR, Pexeva, Prozac/Weekly, sertraline, Zoloft) (If checked, go to 19) ☐

Serotonin-norepinephrine reuptake inhibitors (SNRIs) (e.g., Cymbalta, desvenlafaxine/ER, duloxetine, Effexor/XR, Fetzima, Irenka, Khedezla, Pristiq, venlafaxine/ER) (If checked, go to 19) ☐

Tricyclic antidepressants (TCAs) (e.g., amitriptyline, desipramine, doxepin, Elavil, imipramine, Norpramin, nortriptyline, Pamelor, Surmontil, Tofranil, trimipramine) (If checked, go to 19) ☐

Serotonin modulators (e.g., Trintellix, vortioxetine, Viibryd, vilazodone) (If checked, go to 19) ☐

Other, please specify. (If checked, no further questions) _____

19. Was the therapeutic class of the second antidepressant tried different from the class of the first antidepressant tried? **Y** ☐ **N** ☐

20. Was the trial with the second antidepressant at least 8 weeks in duration?

Yes, please specify trial length (in weeks). (If checked, go to 21) _____

No (If checked, no further questions) ☐

21. Was the second antidepressant titrated up to the maximally tolerated labeled dose? **Y** ☐ **N** ☐

22. Has the patient experienced an inadequate response with an adequate trial of evidenced based psychotherapy (e.g., cognitive behavioral therapy) during the current depressive episode? **Y** ☐ **N** ☐

23. Has the patient experienced an inadequate response with an adequate trial of any of the following augmentation therapies during the current depressive episode: 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, D) An antidepressant and thyroid hormone used concomitantly, E) An antidepressant and buspirone used concomitantly? ACTION REQUIRED: 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 (If checked, no further questions) ☐

Yes, An antidepressant and a second-generation antipsychotic used concomitantly (If checked, no further questions) ☐

Yes, An antidepressant and lithium used concomitantly (If checked, no further questions) ☐

Yes, An antidepressant and thyroid hormone used concomitantly (If checked, no further questions) ☐

Yes, An antidepressant and buspirone used concomitantly (If checked, no further questions) ☐

Other, please specify. (If checked, no further questions) _____

No (If checked, no further questions) ☐

24. Does the patient have a moderate or severe substance or alcohol use disorder that is currently not being treated or medically managed? **Y** ☐ **N** ☐

25. Will the requested drug be prescribed by or in consultation with a psychiatrist? **Y** ☐ **N** ☐

26. 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 Scale [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). **Y** ☐ **N** ☐

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

Less than 18 years old (If checked, no further questions)	☐
Greater than or equal to 18 years old (If checked, go to 28)	☐

28.	Will the requested drug be administered under the direct supervision of a healthcare provider?	**Y**	☐	**N**	☐
29.	Will the patient be monitored by a health care provider for at least 2 hours after administration?	**Y**	☐	**N**	☐
30.	Will the requested drug be used in combination with an oral antidepressant (e.g., duloxetine, escitalopram, sertraline, venlafaxine)?	**Y**	☐	**N**	☐
31.	Does the patient have major depressive disorder with current suicidal ideation with intent?	**Y**	☐	**N**	☐
32.	Does the patient 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?	**Y**	☐	**N**	☐
33.	Does the patient intend to act on thoughts of killing themselves?	**Y**	☐	**N**	☐
34.	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?	**Y**	☐	**N**	☐
35.	Is this a request for continuation of therapy with the requested drug?	**Y**	☐	**N**	☐
36.	Has the patient been treated beyond 4 weeks?	**Y**	☐	**N**	☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

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Prescriber (Or Authorized) Signature and Date