Fax completed prior authorization request form to 800-854-7614 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 www.mercycareaz.org/providers/completecare-forproviders/pharmacy

Spravato Nasal Spray
Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification to support diagnosis

Member Information				
Member Name (first & last):	Date of Birth:	Gender: ☐ Male	☐ Female	Height:
Member ID:	City:	State:		Weight:

Prescribing Provider Information			
Provider Name (first & last):	Specialty:	NPI#	DEA#
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone	Office Fax:	

Dispensing Pharmacy Information		
Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:

Requested Medication Information					
Medication request is NOT for an FDA- approved, or compendia-supported diagnosis (circle one): Yes No	Diagnosis:		ICD-10 Code:		
Are there any contraindications to formulary medications? If yes, please specify:	☐ Yes	☐ No	☐ New request	☐ Continuation of therapy request	
Directions for Use:	Strength:		Dosage Form:		
	Quantity:	Day Supply:	Duration of Therapy/Use:		
What medication(s) has the member tried and failed for this diagnosis? Please specify below.					

Turn-Around Time for Review	
☐ Standard – (24 hours)	☐ **Urgent** – waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: ___________________________

Clinical Information					
Member has a confirmed diagnosis of major depressive disorder as defined by the DSM-V criteria and is treatment resistant?	☐ Yes	☐ No	Spravato is prescribed by or in consultation with a psychiatric provider?	☐ Yes	☐ No
Member does not have an active substance use disorder (SUD)?	☐ Yes	☐ No	Member has an active substance use disorder and the member is currently receiving therapy?	☐ Yes	☐ No

Has member experienced an inadequate response during the current depressive episode with the following therapies? TWO antidepressants from at least TWO different classes having different mechanisms of action at the maximally tolerated labeled dose, each used for at least 4 – 6 weeks? (check any that apply)	☐ AHCCCS preferred SSRI ☐ AHCCCS preferred SNRI ☐ AHCCCS preferred buprenorphine
Has member experienced an inadequate response during the current depressive episode with at least TWO augmentation therapies for at least 4 weeks? (check any that apply)	☐ SSRI or SNRI and a second-generation antipsychotic used concomitantly (aripiprazole, quetiapine, risperidone, olanzapine) ☐ SSRI or SNRI and lithium used concomitantly ☐ SSRI or SNRI and liothyronine (T3) used concomitantly ☐ SSRI or SNRI and mirtazapine

			☐ SSRI and bupropion and buspirone		
Does member have active suicidal ideation and urgent symptom control is necessary?	☐ Yes	☐ No	Will Esketamine be used in combination with an oral antidepressant (e.g., duloxetine, escitalopram, sertraline, venlafaxine)?	☐ Yes	☐ No
Esketamine is administered under the direct supervision of a healthcare provider?	☐ Yes	☐ No	Provider is certified in the Spravato REMS program?	☐ Yes	☐ No
Will member be monitored by a health care provider for at least 2 hours after administration?				☐ Yes	☐ No
☐ **Renewal ONLY**					
Provider attests that the member has documented improvement or sustained improvement in depressive symptoms from baseline?				☐ Yes	☐ No
Member use of esketamine is in combination with an oral antidepressant?	☐ Yes	☐ No	Member administers esketamine under the direct supervision of a healthcare provider?	☐ Yes	☐ No
Provider is certified in the Spravato REMS Program?	☐ Yes	☐ No	Member will be monitored by a health care provider certified by the Spravato REMS Program for at least 2 hours after administration?	☐ Yes	☐ No
Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records.					

Signature affirms that information given on this form is true and accurate and reflects office notes.	
Prescribing Provider's Signature: ______________________________	**Date:** ______________

Please note: Incomplete forms or forms without the chart notes will be returned

Office notes, labs, and medical testing relevant to the request that show medical justification are required.

Standard turnaround time is 24 hours. You can call 800-624-3879 to check the status of a request.