



Fax completed prior authorization request form to 855-247-3677 (Integrated population) or 855-246-7736 (SMI Non-Title population) 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/rbha-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:		Height:	
		<input type="checkbox"/> Male	<input type="checkbox"/> Female		
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:		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> New request	<input type="checkbox"/> 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					
<input type="checkbox"/> Standard – (24 hours)		<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Spravato is prescribed by or in consultation with a psychiatric provider?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Member does not have an active substance use disorder (SUD)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Member has an active substance use disorder and the member is currently receiving therapy?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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)			<input type="checkbox"/> AHCCCS preferred SSRI		
			<input type="checkbox"/> AHCCCS preferred SNRI		
			<input type="checkbox"/> 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)			<input type="checkbox"/> SSRI or SNRI and a second-generation antipsychotic used concomitantly (aripiprazole, quetiapine, risperidone, olanzapine)		
			<input type="checkbox"/> SSRI or SNRI and lithium used concomitantly		
			<input type="checkbox"/> SSRI or SNRI and liothyronine (T3) used concomitantly		
			<input type="checkbox"/> SSRI or SNRI and mirtazapine		

			<input type="checkbox"/> SSRI and bupropion and buspirone		
Does member have active suicidal ideation and urgent symptom control is necessary?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Will Esketamine be used in combination with an oral antidepressant (e.g., duloxetine, escitalopram, sertraline, venlafaxine)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Esketamine is administered under the direct supervision of a healthcare provider?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Provider is certified in the Spravato REMS program?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Will member be monitored by a health care provider for at least 2 hours after administration?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Renewal ONLY					
Provider attests that the member has documented improvement or sustained improvement in depressive symptoms from baseline?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Member use of esketamine is in combination with an oral antidepressant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Member administers esketamine under the direct supervision of a healthcare provider?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Provider is certified in the Spravato REMS Program?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Member will be monitored by a health care provider certified by the Spravato REMS Program for at least 2 hours after administration?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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 800-564-5465 to check the status of a request.