	New Hampshire AIDS Drug Assistance Prior Authorization/Non-Preferred D Spravato®	-	rm									
	DATE OF MEDICATION REQUEST: /	/										
SECTION I:	PATIENT INFORMATION AND MEDICATION	REQUESTED										
	:	FIRST NAME:										
MEDICAID	D NUMBER:	DATE OF BIRTH:		1								
			[
Drug Name Dosing Dire	ctions:		Strength: Length of T	herapy:								
	PRESCRIBER INFORMATION											
		FIRST NAME:										
SPECIALTY:		NPI NUMBER:										
PHONE NU	MBER:	FAX NUMBER:										
		-										
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?
- 3. Is the prescriber a psychiatrist or psychiatric mental health nurse practitioner, or has one of these Yes No specialists been consulted?

(Form continued on next page.)

Fax to Magellan Rx Management if medications will be dispensed by a pharmacy and will be administered by the patient or caregiver at home. Phone: 1-800-424-7901 Fax: 1-800-424-7984



Yes No

	New Hampshire AIDS Drug Assistance Program																				
10.7	Prior Authorization/Non-Preferred Drug Approval Form Spravato®																				
		DATE OF		CATI	ON F	REQU	EST:	/		1											
ΡΑ	TIENT LA	ST NAME:								ΡΑΤΙ	ENT	FIRS		ME:							
SE		: CLINICAL	HISTO	ORY ('CON	TINU	IED)														
4.		e patient h of intracrar ent?		-			-												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 [®] :																					
8.	B. Do you attest to certification of the healthcare setting in the Spravato [®] REMS program?] No										
9.	9. Do you attest that the patient's blood pressure will be monitored prior to each administration Yes No and at least 2 hours after each administration?																				
10	10. Do you attest to reviewing the dosing schedule with the patient and confirmed the patient's Yes N understanding and availability of transportation?] 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.	14. Is the patient receiving electroconvulsive therapy (ECT), vagus nerve stimulation (VNS), Yes N transcranial magnetic stimulation (TMS), or deep brain stimulation (DBS)?] No													
15.	. Has the weeks e	patient trie ach?	ed at l	east	2 dif	feren	t antio	depres	san	ts fro	m dif	ferer	nt cla	sses	for at	least	: 6	[Yes] No
		se describe tional spac									ignif	icant	adve	erse r	eacti	ons. I	f				

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

PRESCRIBER'S	SIGNATURE
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DATE: _____

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