



**New Hampshire AIDS Drug Assistance Program  
Prior Authorization/Non-Preferred Drug Approval Form  
Spravato®**

DATE OF MEDICATION REQUEST:    /    /

**SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED**

LAST NAME:

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FIRST NAME:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

MEDICAID ID NUMBER:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

DATE OF BIRTH:

				-					-				
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GENDER:     Male     Female

Drug Name:

Strength:

Dosing Directions:

Length of Therapy:

**SECTION II: PRESCRIBER INFORMATION**

LAST NAME:

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FIRST NAME:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

SPECIALTY:

NPI NUMBER:

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PHONE NUMBER:

				-					-				
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FAX NUMBER:

				-					-				
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**SECTION III: CLINICAL HISTORY**

- Does the patient have a diagnosis of major depressive disorder (DSM-5)?     Yes     No
- Has a baseline depression assessment been done using a validated depression rating scale?     Yes     No
- Is the prescriber a psychiatrist or psychiatric mental health nurse practitioner, or has one of these specialists been consulted?     Yes     No

*(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

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