



**New Hampshire Medicaid Fee-for-Service 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:

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MEDICAID ID NUMBER:

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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:

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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 Prime Therapeutics Management if medications will be dispensed by a pharmacy and will be administered by the patient or caregiver at home.**

Phone: 1-866-675-7755

Fax: 1-888-603-7696

**Fax to DHHS if medication is dispensed/administered by the office or outpatient setting:**

Phone: 1-603-271-9384

Fax: 1-603-314-8101



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DATE OF MEDICATION REQUEST:     /     /

**PATIENT LAST NAME:**

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**PATIENT FIRST NAME:**

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**SECTION III: CLINICAL HISTORY (CONTINUED)**

4. Does the patient have a diagnosis of aneurysmal vascular disease, arteriovenous malformation, history of intracranial hemorrhage, uncontrolled hypertension, or known hypersensitivity to any component?  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®:
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8. Do you attest to certification of the healthcare setting in the Spravato® REMS program?  Yes  No
9. Do you attest that the patient’s blood pressure will be monitored prior to each administration and at least 2 hours after each administration?  Yes  No
10. Do you attest to reviewing the dosing schedule with the patient and confirmed the patient’s understanding and availability of transportation?  Yes  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. Is the patient receiving electroconvulsive therapy (ECT), vagus nerve stimulation (VNS), transcranial magnetic stimulation (TMS), or deep brain stimulation (DBS)?  Yes  No
15. Has the patient tried at least 2 different antidepressants from different classes for at least 6 weeks each?  Yes  No
- a. Please describe treatment failure, contraindications, or significant adverse reactions. **If additional space is needed, please use another page.**

**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:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

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