Spravato

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical*	❑ *Home*	❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital*	❑ *Office*	❑ *Pharmacy*

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062
Phone: 1-888-877-0518 ● Fax: 1-855-330-1720 ● www.caremark.com

Criteria Questions:

1. What is the diagnosis?
   - ❑ Treatment resistant depression
   - ❑ Major Depressive Disorder with acute suicidal ideation or behavior
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. Does the patient have a moderate or severe substance or alcohol use disorder that is currently not being treated or medically managed? ❑ Yes ❑ No
4. Is this a request for continuation of therapy with the requested drug? ❑ Yes ❑ No *If No, skip to #7*
5. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? If unknown, answer Yes. *If Yes, skip to #7* ❑ Yes ❑ No
6. Has there been improvement or sustained improvement from baseline in depressive symptoms documented by standardized rating scales that reliably measure depressive symptoms (e.g., Beck Depression Scale [BDI], Hamilton Depression Rating Scale [HDRS], Montgomery-Asberg Depression Rating Scale [MADRS], etc.)? ***ACTION REQUIRED: If Yes, attach chart note(s) documenting current depression severity score(s) from standardized rating scale(s).*** ❑ Yes ❑ No *No further questions*
7. Does the patient have a confirmed diagnosis of severe major depressive disorder (single or recurrent episode), documented by standardized rating scales that reliably measure depressive symptoms (e.g., Beck Depression Scale [BDI], Hamilton Depression Rating Scale [HDRS], Montgomery-Asberg Depression Rating Scale [MADRS], etc.)? ***ACTION REQUIRED: If Yes, attach chart note(s) documenting pretreatment depression severity score(s) from standardized rating scale(s).*** ❑ Yes ❑ No
8. Has the diagnosis been verified by a psychiatrist? ❑ Yes ❑ No
9. Will the requested drug be administered under the direct supervision of a healthcare provider? ❑ Yes ❑ No
10. Will the patient be monitored by a health care provider for at least 2 hours after administration? ❑ Yes ❑ No
11. Has the patient experienced an inadequate response with two antidepressants (e.g., selective serotonin reuptake inhibitor [SSRI], serotonin-norepinephrine reuptake inhibitor [SNRI], tricyclic antidepressant [TCA], bupropion, mirtazapine) from two different classes during the current depressive episode? ***ACTION REQUIRED: Attach medical/prescription records or chart note(s) documenting failure with antidepressant agents.***
    If Yes, indicate two different classes.
    - ❑ Aminoketone (Wellbutrin/SR/XL [bupropion])
    - ❑ Monoamine oxidase inhibitors (MAOIs) (e.g., Marplan, Nardil, Parnate, phenelzine, tranylcypromine)
    - ❑ Noradrenaline and specific serotoninergic antidepressants (NASSAs) (e.g., amoxapine, maprotiline, mirtazapine/ODT, Oleptro ER, Remeron/Solutab, trazodone)
    - ❑ Selective serotonin reuptake inhibitors (SSRIs) (e.g., Celexa, citalopram, escitalopram, fluoxetine, fluvoxamine, Lexapro, Luvox/CR, paroxetine, Paxil/CR, Pexeva, Prozac/Weekly, sertraline, Zoloft)
    - ❑ Serotonin-norepinephrine reuptake inhibitors (SNRIs) (e.g., Cymbalta, desvenlafaxine/ER, duloxetine, Effexor/XR, Fetzima, Irenka, Khedezla, Pristiq, venlafaxine/ER)
    - ❑ Tricyclic antidepressants (TCAs) (e.g., amitriptyline, desipramine, doxepin, Elavil, imipramine, Norpramin, nortriptyline, Pamelor, Surmontil, Tofranil, trimipramine)
    - ❑ Other _____
    - ❑ No - none of the above, *skip to #19*
12. Was the length of the trial with the first agent at least 8 weeks in duration? ❑ Yes ❑ No *If No, skip to #19*
    If Yes, indicate trial length: _____ weeks / months / years ***(circle one)***
13. Was the first agent titrated up to the maximally tolerated labeled dose? ❑ Yes ❑ No *If No, skip to #19*
14. Was the therapeutic class of the second agent different from the first agent trialed?
    ❑ Yes ❑ No *If No, skip to #19*

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15. Was the length of the trial with the second agent at least 8 weeks in duration? ❑ Yes ❑ No *If No, skip to #19*
If Yes, indicate trial length: _____ weeks / months / years ***(circle one)***

16. Was the second agent titrated up to the maximally tolerated labeled dose?
❑ Yes ❑ No *If No, skip to #19*

17. Has the patient experienced an inadequate response with an adequate trial of any of the following augmentation therapies during the current depressive episode? ***ACTION REQUIRED: Attach medical/prescription records or chart note(s) documenting failure with augmentation agent(s).***
If Yes, indicate trial length and skip to #23: _____ weeks / months / years (circle one)
❑ Yes - Two antidepressants with different mechanisms of action used concomitantly
❑ Yes - An antidepressant and a second-generation antipsychotic used concomitantly
❑ Yes - An antidepressant and lithium used concomitantly
❑ Yes - An antidepressant and thyroid hormone used concomitantly
❑ Yes - An antidepressant and buspirone used concomitantly
❑ Other _____
❑ No - none of the above

18. Has the patient experienced an inadequate response to an adequate trial of cognitive behavioral therapy during the current depressive episode? *If Yes, skip to #24* ❑ Yes ❑ No

19. Does the patient have major depressive disorder with current suicidal ideation with intent? ❑ Yes ❑ No

20. Does the patient have thoughts, even momentarily, of self-harm with at least some intent or awareness that they may die as a result, or the patient thinks about suicide? ❑ Yes ❑ No

21. Does the patient intend to act on thoughts of killing themselves? ❑ Yes ❑ No

22. Does the prescriber represent that, in the absence of the requested drug, within the next 24 to 48 hours the patient will require confinement in an acute care psychiatric institution? ❑ Yes ❑ No

23. Will the requested drug be used in combination with an oral antidepressant (e.g., duloxetine, escitalopram, sertraline, venlafaxine)? ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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