HIGHMARK HEALTH OPTIONS

Updated: 10/2025
Approved: 10/2025

Request for Prior Authorization for Spravato (esketamine)
Website Form – www.wv.highmarkhealthoptions.com
Submit request via: Fax - 1-833-547-2030.

All requests for Spravato (esketamine) require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Spravato (esketamine) Prior Authorization Criteria:

- The member is 18 years of age and older
- Must have a diagnosis of severe major depressive disorder supported by progress notes or moderate to severe MDD with active suicidal ideation and intent
- The member must not have a history of current (within the past 6 months) substance abuse, dependence, or addiction (excludes nicotine or caffeine).
- Provider attestation of the following:
    - The diagnosis was made using DSM-5 criteria by or in consultation with a mental health provider
    - Spravato (esketamine) will be used in combination with an oral antidepressant for MDD only
    - Spravato (esketamine) will be administered under the supervision of a healthcare provider and the member will be monitored for at least 2 hours after administration
    - The member has been assessed and determined not to be at risk for abuse and misuse of Spravato (esketamine)
- Must provide documentation showing the member has tried and failed or had an intolerance or contraindication for at least 4 weeks to all of the following (at least one failure must have occurred in the past 3 months):
    - a SSRI
    - a SNRI
    - an atypical antidepressant (e.g. bupropion)
- Must provide documentation showing the member has tried and failed for at least 4 weeks both of the following augmentation treatments
    - Two antidepressants used together
    - An antidepressant plus a non-antidepressant medication (e.g. lithium, a second generation antipsychotic, thyroid hormone)
- Documentation of a baseline Montgomery-Åsberg Depression Rating Scale (MADRS) total score.
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- **Initial Duration of Approval:** 3 months
- **Reauthorization criteria**
    - Documentation the member responded to therapy demonstrated by a ≥ 50% improvement from baseline in MADRS total score
        - **Reauthorization Duration of Approval:** 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-

reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

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Spravato (esketamine)
PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX: (833)-547-2030.**
If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: 1-844-325-6251 Mon – Fri 8 am to 7 pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:	
Member ID:	Member weight:	Height:

REQUESTED DRUG INFORMATION

Medication:	Strength:	
Directions:	Quantity:	Refills:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:	
Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No		

Billing Information

This medication will be billed: ☐ at a pharmacy **OR** ☐ medically, JCODE:_____
Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis:	ICD Code:

Has member had history of current (within past 6 months) substance abuse, dependence, or addiction (excludes nicotine or caffeine) ☐ Yes ☐ No
Was the diagnosis made using DSM-5 criteria by or in consultation with a mental health provider? ☐ Yes ☐ No
Spravato (esketamine) will be used in combination with an oral antidepressant for MDD only ☐ Yes ☐ No
Spravato (esketamine) will be administered under the supervision for healthcare provider and the member will be monitored for at least 2 hours after administration? ☐ Yes ☐ No
Member has been addressed and determined not to be at risk for abuse and misuse of Spravato (esketamine) ☐ Yes ☐ No
Baseline Montgomery-Asberg Depression Rating Scale (MADRS) total score: _____

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION

Documentation member responded to therapy demonstrated by a ≥ 50% improvement from baseline in MADRS total score_____
Has the member experienced an improvement with treatment? ☐ Yes ☐ No

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date