HIGHMARK HEALTH OPTIONS

Updated: 01/2024
DMMA Approved: 01/2024

Request for Prior Authorization for Spravato (esketamine)
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

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:
Coverage may be provided with a diagnosis of treatment-resistant depression or depressive symptoms with major depressive disorder (MDD) with acute suicidal ideation or behavior and the following criteria is met:

- The member is 18 years of age and older
- Must have a diagnosis of severe major depressive disorder without psychotic features 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
    - 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.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.

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SPRAVATO (ESKETAMINE)
PRIOR AUTHORIZATION FORM– PAGE 1 of 2

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:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6251 Mon-Fri 8:00am to 7:00pm

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: ☐ Treatment Resistant Severe Major Depressive Disorder without psychotic features
☐ Depressive symptoms with Major Depressive Disorder with acute suicidal ideation or behavior
☐ Other: _____(*please provide documentation of how diagnosis was determined)*
Was the diagnosis made using DSM-5 criteria by or in consultation with a mental health provider?
☐ Yes ☐ No
Please select all of the following that apply:
☐ The member does not have a history of substance abuse, dependence or addiction (excludes nicotine or caffeine)
☐ The medication will be used in combination with an oral antidepressant
☐ The medication will be administered under the supervision of a healthcare provider
☐ The member will be monitored for at least 2 hours after each administration of the medication by a healthcare provider
☐ The member has been assessed by a health care provider and has been determined not to be at risk for abuse or misuse of the requested medication
☐ The member has active suicidal ideation and intent

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SPRAVATO (ESKETAMINE)
PRIOR AUTHORIZATION FORM (CONTINUED) – PAGE 2 OF 2

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:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6253 Monday through Friday 8:00am to 7:00pm

MEMBER INFORMATION

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

CURRENT or PREVIOUS THERAPY

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

Please provide documentation of the member's baseline Montgomery-Asberg Depression Rating Scale Score (MADRS): _____ Date taken: _____

REAUTHORIZATION

Please provide documentation of the member's **baseline** Montgomery-Asberg Depression Rating Scale Score (MADRS): _____ Date taken: _____

Please provide documentation of the member's **current** Montgomery-Asberg Depression Rating Scale Score (MADRS): _____ Date taken: _____

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date