HEALTH PLANS
UNIVERSITY OF UTAH

PRIOR AUTHORIZATION REQUEST FORM
KETAMINE, SPRAVATO®

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department. Failure to submit clinical documentation to support this request will result in delay and/or denial of the request.

- For **Medical Pharmacy** please fax requests to 801-213-1547.
- For **Retail Pharmacy** requests please fax requests to: 888-509-8142

If you have prior authorization questions, please call for assistance: Healthy U: 855-856-5694, University of Utah Health Employees: 855-856-5690, Individual & Family Plans: 855-869-4769, Commercial Groups: 855-859-4892, MHC: 855-885-7695, Advantage U Part B: 888-605-0858

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred: ☐ ketamine intravenous injection
Non-preferred: ☐ Spravato® (esketamine)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
KETAMINE			
1. Is the member 18 years of age or older?	☐	☐	
2. Does the member have active suicidal ideation?	☐	☐	**Please provide documentation**
3. Has the member had an inadequate response to at least an 8 week trial of the maximum tolerated dose of 3 antidepressants, each from a different antidepressant class?	☐	☐	**Please provide documentation**
SPRAVATO®			
1. Is the member 18 years of age or older?	☐	☐	
2. Does the member have active suicidal ideation?	☐	☐	**Please provide documentation**
3. Has the member had an inadequate response to intravenous ketamine treatment?	☐	☐	**Please provide documentation**
4. Has the member had an inadequate response to at least an 8 week trial of the maximum tolerated dose of 3 antidepressants, each from a different antidepressant class?	☐	☐	**Please provide documentation**
5. Does the member have a recent history of substance abuse or alcohol use disorder?	☐	☐	
REAUTHORIZATION			

1. Is the requesting for reauthorization of therapy?	☐	☐	
2. Has member been compliant with their primary antidepressant?	☐	☐	
3. Does clinical documentation show continued medical necessity and a positive clinical response defined as ≥ 50% reduction in symptoms compared to baseline?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:

Physician Signature:

****Failure to submit clinical documentation to support this request will result in delay and/or denial of the request****

Policy PHARM- 069
Origination Date: 07/19/2019
Reviewed/Revised Date: 08/19/2020
Next Review Date: 08/19/2021
Current Effective Date: 09/01/2020