HEALTH PLANS
UNIVERSITY OF UTAH

# PRIOR AUTHORIZATION REQUEST FORM
## KETAMINE

**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

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

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 a diagnosis of moderate to severe major depressive disorder? | ☐ | ☐ | **Please provide documentation** |
| 3. Has the member been taking an antidepressant and will treatment with an antidepressant continue while taking ketamine? | ☐ | ☐ | |
| 4. Does clinical documentation show one of the following:<br>• Does the member have active suicidal ideation?<br>• Has the member had an inadequate response to at least an 8-week trial of the maximum tolerated dose of three 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 request 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-M036
Origination Date: 08/03/2021
Reviewed/Revised Date: 08/18/2021
Next Review Date: 08/18/2022
Current Effective Date: 09/01/2021