

(This and other PA forms are posted on [www.ctdssmap.com](http://www.ctdssmap.com) and can be accessed by clicking on the pharmacy icon)

**CT Medical Assistance Program  
 SPRAVATO Pharmacy Prior Authorization (PA) Request Form  
 To Be Completed by Prescriber  
Who is Administering Only (NOT DISPENSING)**

<u>Prescriber Information</u>	<u>Patient Information</u>
Prescriber's NPI:	Patient Medicaid ID Number:
Prescriber Name:	Patient Name:
Phone #: ( )	Patient DOB:
Fax #: ( )	Primary ICD Diagnosis Code:
<u>SPRAVATO Prescription Information</u>	
Dose/frequency:	Requested Start Date:
<input type="checkbox"/> New therapy <input type="checkbox"/> Continuation	Expected Duration:

**This form must be completed by the prescribing provider. If the form is missing information, the PA will not be processed. In completing and submitting this form for prior-authorization, I attest that I am registered in the Spravato Risk Evaluation and Mitigating Strategy (REMS) program, and legally authorized to prescribe and administer Spravato. If you are not REMS certified, you are not allowed to prescribe this drug.**

**Clinical Information**

1.	Is the patient 18 years of age or older?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Has the patient experienced treatment-resistant depression (TRD)	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Has the patient experienced treatment failure (at least a 4-week trial) or adverse effects from the use of a SSRI and one other antidepressant (Non-SSRI)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Has the patient experienced an inadequate response (defined as at least four weeks of therapy for antidepressants) or adverse reaction to one of the below mentioned antidepressant augmentation strategies or does the patient have a contraindication to all of the below mentioned augmentation strategies: 1. second-generation antipsychotic 2. lithium 3. a second antidepressant from a different class 4. thyroid hormone	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	Is this a continuation of Spravato started in an inpatient unit for treatment of acute suicidal ideation?	<input type="checkbox"/> Yes <input type="checkbox"/> No

- If you answered 'NO' to any of the questions 1 through 4 above, and also answered 'NO' to question 5, this form and a Letter of Medical Necessity (LMN) must be reviewed by CT BHP for consideration. Please provide all relevant information relating to the medical necessity (see Conn. Gen. Stat § 17b-259b(a)) of Spravato for this patient. Submit request to CT BHP via fax, to 866-434-7681.
- If you answered 'YES' to questions 1 through 4 above, or answered 'YES' to questions 1 and 5, please fax the completed form to the Gainwell Technologies Pharmacy PA Assistance Center at the number above for processing.

I certify that documentation is maintained in my files and the information given is true and accurate for the medication requested, subject to penalty under section 17b-99 of the Connecticut General Statutes and sections 17-83k-1-13 and 4a-7, inclusive, of the Regulations of Connecticut State Agencies. I certify that the client is under my clinic's/practice's ongoing care. I certify that I am a practitioner and hold a current, unrestricted license that allows me to prescribe medication and that I am enrolled in the CT Medical Assistance Program.

**Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_