STATE OF CONNECTICUT DEPARTMENT OF SOCIAL SERVICES
TELEPHONE: 1-877-552-8247 FAX: 1-860-575-6532

CT Medical Assistance Program
SPRAVATO Professional Prior Authorization (PA) Request Form
To Be Completed by Prescriber
Who is both Dispensing and Administering

Prescriber Information	**Patient Information**
Prescriber's NPI:	Patient Medicaid ID Number:
Prescriber Name:	Patient Name:
Billing Group ID#:	Patient DOB: / /
Phone #: ( )	Primary ICD Diagnosis Code:
Fax #: ( )	
SPRAVATO Prescription Information	
Dose/frequency:	Requested Start Date:
□ New therapy □ 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?	□ Yes	□ No
2	Has the patient experienced treatment-resistant depression (TRD)?	□ Yes	□ 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)?	□ Yes	□ 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	□ Yes	□ No
5.	Is this a continuation of Spravato started in an inpatient unit for treatment of acute suicidal ideation?	□ Yes	□ 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 CT BHP to 866-434-7681.**

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:_____