PRIOR AUTHORIZATION FORM
Spravato - Medicare

Unless otherwise indicated below, authorization quantities are limited to the manufacturer recommended dosage

P.O. Box 30192
Salt Lake City, UT 84130-0192
SELECTHEALTH.ORG

Complete online at www.selecthealth.org/pa or fax back to: 801-650-3170 **For questions or clarifications, call: 801-442-9988 or 855-442-9988**	
Patient Information	
Patient's Name:	Patient's Date of Birth:
Patient's ID:	Patient's Phone #:
Diagnosis Code(s):	
Requesting Provider Information	
Name:	Phone #:
NPI/DEA:	Fax #:
Address:	Supervising Physician (if requesting provider bills under a different provider)
	Name:
	NPI/DEA:
Servicing Provider Information (if different than requesting provider)	
Name of provider or facility:	Phone number:
NPI/DEA:	Address:

Drug Name and Strength:	Directions / SIG:
☐ Urgent Request (24 hours)	☐ Standard Request (72 hours)

Q1. Is this a reauthorization request?	
☐ Yes	☐ No
Q2. Is the medication being prescribed by or in consultation with a psychiatrist?	
☐ Yes	☐ No
Q3. Is the patient 18 years of age or older?	
☐ Yes	☐ No
Q4. What is the patient's diagnosis?	
☐ Major depressive disorder (moderate to severe)	☐ Other

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Q5. If other, please specify:

Q6. Is the patient currently experiencing a major depressive episode?

☐ Yes ☐ No

Q7. Have the patient's depression symptoms been evaluated using a standard rating scale that reliably measures depression symptoms?

☐ Yes ☐ No

Q8. Please list rating scale and score:

Q9. Will Spravato be administered under the direct supervision of a healthcare provider?

☐ Yes ☐ No

Q10. Will each treatment session consist of a two-hour post-administration observation under supervision?

☐ Yes ☐ No

Q11. Has the patient previously had an inadequate response to at least two different antidepressants of adequate dose and duration?

☐ Yes ☐ No

Q12. If yes, please list previous antidepressant therapy including dose and duration:

Q13. Will a new oral antidepressant be initiated along with Spravato?

☐ Yes ☐ No

Q14. In the provider's professional clinical opinion, has the patient demonstrated a readiness to initiate treatment? (Including a plan and schedule for dosing and transportation)

☐ Yes ☐ No

Q15. For reauthorization, has the patient been adherent to both Spravato therapy and oral antidepressant therapy?

☐ Yes ☐ No

Q16. For reauthorization, has the patient been re-evaluated and shown improvement on a standard rating scale that reliably measures depression symptoms?

☐ Yes ☐ No

Q17. Chart Notes are required for the request of this medication. Failure to provide chart notes will result in a delay in decision and/or denial. Did you attach relevant chart notes?

☐ Yes ☐ No

Q18. Additional comments:

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This form is intended for SelectHealth members only. All requests for preauthorization should be sent via fax to 1-801-442-0413. Missing, inaccurate, or incomplete information may cause a delay or denial of authorization.

______________________________ ______________________________

Prescriber Signature Date

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