PRIOR AUTHORIZATION FORM
Spravato - Commercial

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

SCRIPIUS
a service of selecthealth.
P.O. Box 30192 Salt Lake City, UT 84130

Complete online at www.selecthealth.org/pa or fax back to: 801-442-3006
For questions or clarifications, call: 800-442-3129

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:

Q1. Is this a reauthorization request?
☐ Yes ☐ No

Q2. Is the patient 18 years of age or older?
☐ Yes ☐ No

Q3. What is the patient's diagnosis?
☐ Major depressive disorder (moderate to severe) ☐ Other

Q4. If other, please specify:

Q5. Is the patient currently experiencing a major depressive episode?
☐ Yes ☐ No

Q6. Have the patient's depression symptoms been evaluated using a standard rating scale that reliably measures

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depression symptoms? ☐ Yes ☐ No
Q7. Please list rating scale and score:
Q8. Will Spravato be administered under the direct supervision of a healthcare provider? ☐ Yes ☐ No
Q9. Will each treatment session consist of a two-hour post-administration observation under supervision? ☐ Yes ☐ No
Q10. Has the patient previously had an inadequate response to at least two different antidepressants of adequate dose and duration? ☐ Yes ☐ No
Q11. If yes, please list previous antidepressant therapy including dose and duration:
Q12. Will a new oral antidepressant be initiated along with Spravato? ☐ Yes ☐ No
Q13. 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
Q14. For reauthorization, has the patient been adherent to both Spravato therapy and oral antidepressant therapy? ☐ Yes ☐ No
Q15. For reauthorization, has the patient been re-evaluated and shown improvement on a standard rating scale that reliably measures depression symptoms? ☐ Yes ☐ No
Q16. Additional comments:

This form is intended for SelectHealth members only. All requests for preauthorization should be sent via fax to 1-801-442-3006. Missing, inaccurate, or incomplete information may cause a delay or denial of authorization.

Prescriber Signature

Date

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