Print Reset

NYRx, the Medicaid Pharmacy Program
Spravato® (esketamine) Nasal Spray
Prior Authorization Request Form

Fax form to 1-800-268-2990 | Requests are responded to within 24 hours

INSTRUCTIONS

Please fill out all sections on all pages completely and legibly.

MEMBER INFORMATION

Member Last Name: _____

Member First Name: _____

Member Medicaid ID (two letters, five numbers, one letter): _____

Date of Birth (MM/DD/YYYY): _____ Sex: ☐ Male ☐ Female ☐ X

Height (in/cm): _____ Weight (lb/kg): _____ Allergies: _____

PRESCRIBER INFORMATION

Prescriber Last Name: _____

Prescriber First Name: _____

Prescriber NPI: _____ Specialty: _____

Prescriber Street Address: _____

City: _____ State: _____ Zip: _____

Prescriber Phone: _____ Prescriber Fax: _____

Prescriber's Authorized Agent (Full Name): _____

Note: An authorized agent is an employee of the prescriber who has access to the member's medical records and is submitting this form on the prescriber's behalf. PA requests submitted by third parties will not be accepted.

MEDICATION AND DISPENSING INFORMATION

Drug Name and Strength:

☐ Spravato 56 mg Dose Kit: Two 28 mg nasal spray devices

☐ Spravato 84 mg Dose Kit: Three 28 mg nasal spray devices

Quantity: _____ Dosing Frequency: _____

Directions: _____

Date of drug administration (MM/DD/YYYY): _____

Revision Date: 04/21/2025

Member Last Name: _____ Date of Birth (MM/DD/YYYY): _____

Is this a new prescription?

☐ Yes ☐ No

If **No**, provide date therapy was initiated (MM/DD/YYYY): _____

CLINICAL CRITERIA: DIAGNOSIS

What is the member's diagnosis (select one)?

☐ Treatment-resistant depression (TRD)

☐ Depressive symptoms in adults with major depressive disorder (MDD) associated with acute suicidal ideation or behavior

CLINICAL CRITERIA: INITIATION OF THERAPY

1. Before initiating esketamine nasal therapy, was a baseline score on a depression assessment tool (e.g., 17-item Hamilton Rating Scale for Depression [HAMD17], 16-item Quick Inventory of Depressive Symptomatology [QIDS-C16], 10-item Montgomery-Asberg Depression Rating Scale [MADRS]) obtained?

   ☐ Yes ☐ No

2. For the initial request for members with a diagnosis of **TRD**, has the member had a trial of at least two oral antidepressants prior to initiating esketamine intranasal therapy?

   ☐ Yes ☐ No

3. Provide the names of the most recent antidepressant therapies and dates of the trials:

   Antidepressant and Strength #1: _____

   Date of Use (MM/DD/YYYY): _____

   Antidepressant and Strength #2: _____

   Date of Use (MM/DD/YYYY): _____

4. Was the member observed by a healthcare practitioner for two hours during and after esketamine administration?

   ☐ Yes ☐ No

5. For the indication of **MDD**, is the member on an oral antidepressant in conjunction with esketamine nasal spray?

   ☐ Yes ☐ No

   Antidepressant and Strength: _____

   Directions for Use: _____

Member Last Name: _____ Date of Birth (MM/DD/YYYY): _____

CLINICAL CRITERIA: CONTINUTATION OF THERAPY

1. Utilizing the same baseline depression assessment tool, was there an improvement in the member's score while receiving esketamine treatment?

   ☐ Yes ☐ No

2. Was the member observed by a healthcare practitioner for two hours during and after esketamine administration?

   ☐ Yes ☐ No

3. For the indication of **MDD**, is the member on an antidepressant in conjunction with esketamine intranasal therapy?

   ☐ Yes ☐ No

   Antidepressant and Strength: _____

   Directions for Use: _____

ATTESTATION

I attest that this drug is medically necessary for this member and that all of the information on this form is accurate to the best of my knowledge. I attest that documentation of the above diagnosis and medical necessity is available for review if requested by the New York State Medicaid Program.

_____ _____

Prescriber Signature (Required) Date (MM/DD/YYYY)

Submission of this form confirms the information is accurate and true, and that the supporting documentation is available for review upon request of the NYSDOH or CMS. The submitter understands that any person who knowingly makes or causes to be made a false record to statement that is material to a Medicaid claim may be subject to civil penalties and treble damages under both federal and NYS False Claims Acts.

Fax the completed form to the NYRx Clinical Call Center at 1-800-268-2990.

To contact the NYRx Clinical Call Center, please call 1-877-309-9493.