Field Name	Field Description
Prior Authorization Group Description	**Spravato**
Drugs	**Spravato** (esketamine)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	Patients must be 18 years age or older
Prescriber Restrictions	N/A
Coverage Duration	If all of the criteria are met, the initial request will be approved for 4 weeks. For continuation of therapy the request will be approved for 6 months.
Other Criteria	**Initial Authorization:** • Member has a diagnosis of at least one of the following: o Major depressive disorder with treatment-resistant depression o Major depressive disorder with acute suicidal ideation or behavior • Medication is being prescribed at an FDA approved dosage. • Prescriber attests Spravato will be used in conjunction with an oral antidepressant • If Spravato is being requested for a diagnosis of major depressive disorder with treatment-resistant depression (i.e. without suicidal ideation or behavior) the member has either: o Documented trial and failure of two preferred oral antidepressants (eg. SSRIs, SNRIs, TCAs) of at least a minimum effective dose for four (4) weeks or longer OR o Medical justification as to why the patient cannot use preferred alternative(s). **Re-authorization:** • Medication is prescribed at an FDA-approved dosage. • Medication is being used in conjunction with an oral antidepressant. • Documentation was submitted indicating the member has clinically benefited from therapy.
Revision/Review Date	**Medical Director/clinical reviewer must override criteria when,**

10/2023	**in his/her professional judgement, the requested item is medically necessary.**

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Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	Patient must be 18 years age or older
Prescriber Restrictions	N/A
Coverage Duration	If all of the criteria are met, the initial request will be approved for 4 weeks. For continuation of therapy, the request will be approved for 6 months.
Other Criteria Revision/Review Date: 10/2023	**Initial Authorization:** • Member has a diagnosis of at least one of the following: o Major depressive disorder with treatment-resistant depression o Major depressive disorder with acute suicidal ideation or behavior • Prescriber attests Spravato will be used in conjunction with an oral antidepressant. • Medication is being prescribed at an FDA approved dosage. • If Spravato is being requested for a diagnosis of major depressive disorder with treatment-resistant depression (i.e. without suicidal ideation or behavior) the member has either: o Documented trial and failure of two preferred oral antidepressants (eg. SSRIs, SNRIs, TCAs) of at least a minimum effective dose for four (4) weeks or longer OR o Medical justification as to why the patient cannot use preferred alternative(s). **Re-authorization:** • Medication is prescribed at an FDA-approved dosage. • Medication is being used in conjunction with an oral antidepressant. • Documentation was submitted indicating the member has clinically benefited from therapy. **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

PerformRx recommends approving the Spravato prior authorization criteria for ACDE with the following changes:

1) Update prescriber antidepressant use to prescriber attestation of antidepressant use for consistency with Enterprise criteria
2) Formatting changes for clarity and consistency