Uniform medical drug prior authorization request form

Contains confidential patient information

Complete this form in its entirety and send to Rocky Mountain Health Plans at 833-787-9448

☐ **Urgent**[1]	☐ **Non-urgent**
Requested drug name: Ketalar (ketamine) – Medicaid	
Patient information:	**Prescribing provider information:**
Patient name:	**Prescriber name:**
Member/subscriber number:	**Prescriber fax:**
Policy/group number:	**Prescriber phone:**
Patient date of birth (MM/DD/YYYY):	**Prescriber pager:**
Patient address:	**Prescriber address:**
Patient phone:	**Prescriber office contact:**
Patient email address:	**Prescriber NPI:**
Prescription date:	**Prescriber DEA:**
Specialty/Facility name (if applicable):	
Prescriber email address:	
Prior authorization request for drug benefit: ☐ **New request** ☐ **Reauthorization**	
Patient diagnosis and ICD diagnostic code(s):	
Drug(s) requested (with J-Code, if applicable):	
Strength/Route/Frequency:	
Unit/Volume of named drug(s):	
Start date and expected length of therapy:	
Location of treatment: (e.g., provider office, facility, home health, etc.) including name, Type 2 NPI (if applicable), address and tax ID:	

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Clinical criteria for approval, including other pertinent information to support the request, other medications tried, their name(s), duration and patient response

Ketalar (ketamine) – J3490

☐ Diagnosis (documentation supportive of diagnosis required)

☐ Major depressive disorder (MDD) – F33.9

☐ Other (please state):

Clinical consideration (for approval, please indicate and provide documentation of the following):

Initial request

1. **Patient has been assessed for current major depressive disorder episode**
   - ☐ Yes: please list assessment tool used (MADRS, PHQ-9, etc.) and related score and attach clinical evaluation
   - ☐ No (does not meet criteria)
2. **Ketalar will be initiated along with a new oral antidepressant or partial response to recent antidepressant start**
   - ☐ Yes (please list antidepressant, dosage, length of time on medication): ☐ No (does not meet criteria)
3. **Patient has previously had adequate trial (10-12 continuous weeks) of at least 2 different oral antidepressants within the last 365 days**

   Note: Rocky Mountain Health Plans does check pharmacy claims history to support adherence.

   ☐ Yes (please list): 1. Drug name: Dose: Period:

   _____ _____ _____

   2. Drug name: Dose: Period:

   _____ _____ _____

   ☐ No (Does not meet criteria)
4. **Provider attests to the following:**
   - ☐ Patient does NOT have active psychotic symptoms, manic symptoms or history of primary psychotic disorder
   - ☐ Patient does NOT have uncontrolled hypertension
   - ☐ Patient does NOT have a history of ketamine abuse or dependence ongoing alcohol or substance use disorder
   - ☐ Provider has explained to the patient that this is a non-FDA-approved use of ketamine and has educated patient to alternatives, risks and benefits

Note: Approval is per episode with the duration of 8 infusions over up to 2 months when all criteria are met.

Provider specialty:

☐ Psychiatry

☐ Other (please state):

Ketalar will be prescribed by, or in consultation with, a mental health provider: ☐ **Yes** ☐ **No**

☐ **For use in clinical trial?** ☐ **Yes** ☐ **No** **(If yes, provide trial name and registration number):**		
Drug name (brand name and scientific name)/Strength:		
Dose:	**Route:**	**Frequency:**
Quantity:	**Number of refills:**	
Product will be delivered to: ☐ **Patient's home** ☐ **Physician office** ☐ **Other:**		
Signature		
Prescriber or authorized signature:		**Date:**
Dispensing pharmacy name and phone number:		
☐ **Approved** ☐ **Denied**		
If denied, provide reason for denial, and include other potential alternative medications, if applicable, that are found in the formulary of the carrier:		

[1] A request for prior authorization that if determined in the time allowed for non-urgent requests could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function, or subject the person to severe pain that cannot be adequately managed without the drug benefit contained in the prior authorization request.

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