South Dakota Department of Social Services

DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
700 GOVERNORS DRIVE
PIERRE, SD 57501-22941

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WEB: DSS Medicaid Prior Authorizations | **EMAIL :** DSSMedicaidpa@state.sd.us

SPRAVATO PRIOR AUTHORIZATION REQUEST FORM

This form **MUST BE** submitted with medical records to support services

Date:		
RECEIPIENT INFORMATION		
Medicaid ID:	**Date of Birth:**	**Sex:** M ☐ F ☐
Last Name:	**First Name:**	
GENERAL INFORMATION		
First Date of Service:	**Last Date of Service:**	
Primary Diagnosis Code:	**HCPC Code:**	
Drug Name:	**Quantity:**	
Hospitalizations/Treatments/Medications Used in the last 6 months:		
POINT OF CONTACT		
Name and Title:		
Email:	**Phone:**	**Fax:**
Note: *The point of contact is the individual completing the PA and would be the contact for questions SD Medicaid may have regarding the PA. The determination notice will be sent to the listed point of contact.*		
REFERRING PROVIDER INFORMATION		
Name:		
NPI #:	**Taxonomy:**	
Phone:	**Fax:**	
SERVICING PROVIDER INFORMATION		
Name:		
Address:		
NPI #:	**Taxonomy:**	
Phone:	**Fax:**	

CRITERIA			
	Medical records to support use of product are submitted		
Initial Therapy (check one)		**Yes** ☐	**No** ☐
☐	Therapy is prescribed by or in consultation with a psychiatrist		
☐	Individual has a diagnosis of major depressive disorder with suicidality or treatment resistant depression as indicated by DSM-5 criteria and/or an appropriate depression rating scale (ex. HAM-D, MADRS, PHQ-9, etc.)		
☐	Individual has previously failed therapy up to maximally indicated doses with **at least two** antidepressants (≥4 week trial of each) from **at least two** of the classes listed below: ☐ Selective Serotonin Reuptake Inhibitor (SSRI) ☐ Selective Norepinephrine Reuptake Inhibitor (SNRI) ☐ Tricyclic Antidepressant (TCA) ☐ Bupropion		
☐	Individual has failed antidepressant augmentation therapy (≥4 week trial) with **one** of the following: ☐ Atypical antipsychotic FDA approved for MDD ☐ Lithium ☐ Thyroid hormones		
☐	Therapy will not be used in combination with electroconvulsive therapy (ECT), vagus nerve stimulation (VNS), transcranial magnetic stimulation (TMS) or deep brain stimulation (DBS)		
☐	Individual has not previously failed ketamine therapy and esketamine therapy will not be used in conjunction with ketamine		
☐	Therapy will be used in conjunction with an oral antidepressant		
☐	Individual is ≥18 years of age		
Continuation of Therapy (check one)		**Yes** ☐	**No** ☐
☐	Individual continues to meet initial criteria		
☐	Individual has shown benefit to therapy as indicated by a 50% reduction in disease severity compared to baseline scoring test		
PHYSICIAN SIGNATURE – PROVIDER ONLY			
This form must be signed by a provider			
☐	I certify that the information given in this form is a true and accurate medical indication for the required product		
Name & Title (Printed):		**Specialty:**	
Signature:			