

Esketamine (Spravato)

Goal(s):

- To ensure safe and appropriate use of esketamine in patients with treatment-resistant depression or suicidal ideation.

Length of Authorization:

- Up to 6 months

Requires PA:

- Esketamine (pharmacy and physician administered claims).

Covered Alternatives:

- Current PMPDP preferred drug list per OAR 410-121-0030 at www.orpdl.org
- Searchable site for Oregon FFS Drug Class listed at www.orpdl.org/drugs/

Approval Criteria		
1. What diagnosis is being treated?	Record ICD10 code.	
2. Is this an FDA approved indication?	Yes: Go to #3	No: Pass to RPh. Deny; medical appropriateness
3. Is the request for maintenance dosing of esketamine (for determining response to therapy) OR for continuation after initiation during a recent hospitalization?	Yes: Go to Renewal Criteria	No: Go to #4
4. Is the patient 65 years or older?	Yes: Pass to RPh. Deny; medical appropriateness.	No: Go to #5
5. Is the member currently engaged in or been referred for psychotherapy?	Yes: Go to #6	No: Pass to RPh. Deny; medical appropriateness.

Approval Criteria

<p>6. Is there prescriber attestation or documentation of treatment-resistant depression based on all the following criteria:</p> <ul style="list-style-type: none">a. Diagnosis of unipolar major depressive disorderb. Patient has tried at least 2 different antidepressants in which:<ul style="list-style-type: none">i. There has been inadequate response after at least 6 weeks of treatment at an average minimum therapeutic dose or greater; orii. The patient has not been able to continue treatment for at least 6 weeks due to intolerable side effects. <p>Minimum therapeutic doses can be found here: https://www.oregon.gov/oha/HPA/DSI-Pharmacy/MHCAGDocs/Switching-Between-Anti-Depressant-Medications.pdf</p>	<p>Yes: Go to #9</p>	<p>No: Go to #7</p>
<p>7. Is the request for treatment of major depressive disorder in the setting of acute suicidal ideation or behavior?</p>	<p>Yes: Go to #8</p>	<p>No: Pass to RPh. Deny; medical appropriateness.</p> <p>Recommend an adequate trial (minimum of 6-8 weeks) of 2 or more antidepressants.</p>
<p>8. Is there a documented plan to optimize oral antidepressant treatment in one of the following ways:</p> <ul style="list-style-type: none">a. Titrating the dose of the current antidepressant to a therapeutic levelb. Switching to a different antidepressant ORc. Adding oral augmentation therapy (e.g., a second antidepressant, an atypical antipsychotic, or mood stabilizer)?	<p>Yes: Go to #9</p>	<p>No: Pass to RPh. Deny; medical appropriateness.</p>

Approval Criteria

<p>9. Does the patient have documentation of any of the following:</p> <ul style="list-style-type: none"> • Current Aneurysmal vascular disease or arterial venous malformation OR • History of Intracerebral hemorrhage OR • Current Pregnancy OR • Current Uncontrolled hypertension (e.g., >140/90 mmHg) 	<p>Yes: Pass to RPh. Deny; medical appropriateness.</p>	<p>No: Approve up to 28 days for induction (either 56 mg and/or 84 mg for titration) not to exceed 24 units total to be covered within the approved time window.</p> <p>The approved time window typically spans 60 days to accommodate scheduling visits.</p>
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Renewal Criteria

<p>1. Is there documentation that the patient demonstrated an adequate response during the 4-week induction phase (an improvement in depressive symptoms)?</p>	<p>Yes: Go to #2</p>	<p>No: Go to #3</p>
<p>2. Is the request for administration of esketamine once weekly or every 2 weeks?</p>	<p>Yes: Approve for up to 6 months (maximum of 12 per 28 days)</p>	<p>No: Pass to RPh. Deny; medical appropriateness.</p>
<p>3. Has the patient been on therapy for at least 4 weeks?</p>	<p>Yes: Pass to RPh. Deny; medical appropriateness.</p>	<p>No: Approve for completion of induction phase (total 28 days of treatment with a maximum of 24 nasal spray devices (each device contains 28 mg of esketamine))</p>

P&T/DUR Review: 2/26 (KS); 6/25(SS);6/24(KS);2/24; 12/23; 2/23, 10/21; 2/21; 7/19
 Implementation 8/1/25; 7/1/24; 1/1/22; 3/1/21; 8/19/19