MACOMB COUNTY COMMUNITY MENTAL HEALTH
PRIOR AUTHORIZATION REQUEST FORM - SPRAVATO

(PLEASE TYPE OR PRINT)

Consumer Name _____IP Facility Name (if applicable) and Admission Date: _____

Guardian:_____OP Program Name _____

MCCMH Case #:_____ D.O.B. _____ Insurance: □ Indigent □ Caid □ Care/Caid □ Other _____

I. DSM V DIAGNOSIS

	ICD10 Code #
Diagnosis	

II. (A). LEVEL OF TREATMENT SERVICE REQUESTED:

□ Initial Request □ Continuation/Maintenance Request

___Acute Inpatient _____Outpatient

# of Previous Trials to Date _____

Frequency of administration (if continuation is needed, approvals are reevaluated Q 3 months):_____

II. (B). RECOMMENDATION FOR SPRAVATO DOCUMENTED AND AGREEMENT FROM OUTPATIENT TREATING PSYCHIATRIST:

Outpatient Psychiatrist Name _____ Date Contacted: _____

III. (C) WHEN SPRAVATO INITIATED INPATIENT, PLEASE IDENTIFY THE PLAN FOR FOLLOW UP AND/OR CONTINUED TREATMENT OF SPRAVATO PATIENTS AFTER DISCHARGE:(Make sure this meets MCCMH Spravato Policy requirements)

_____

_____

_____

III. (A). DESCRIBE PATIENT'S CURRENT CLINICAL STATUS AND RATIONALE FOR PROPOSED INITIAL ECT (include target symptoms):

a. Legal Status: Voluntary _____ Involuntary _____ Court Order Date & Type:_____

b. Level of depression: Severe _____ Moderate _____ Mild _____ As Evidenced By _____

c. Neurovegetative Symptoms: Sleep: Appetite: Weight:

d. Level of Suicidality: (Check) Ideation Intent Plan Means Attempt: Recent Past

e. Any Psychotic Symptoms: (As Evidenced By)_____

f. Co-Morbid Substance Abuse: (Substance(s) used)_____

g. Significant Personality Disorder and or Intellectual Disability related Behaviors: _____

III. (B). PLEASE EXPLAIN RATIONALE FOR REQUEST OF ADDITIONAL TREATMENT AND INDICATE HOW THE EFFECTIVENESS OF PREVIOUS TREATMENT IS MEASURED (Continuation Request):

III. (C). PLEASE REPORT SYMPTOMS/PROBLEMS PRIOR TO TREATMENT (pre-morbid state):

III. (D) PLEASE REPORT SYMPTOMS/PROBLEMS AFTER TREATMENT (post-morbid state):

IV. LIST OF SIGNIFICANT MEDICAL PROBLEMS (Initial Request):

V. LIST OF ALL **CURRENT** MEDICATIONS (Initial and Continuation Requests):

Drug Name	Strength	Dosing Schedule	Date Initiated

VI. PAST TREATMENT HISTORY (Initial Request):

A. Psychiatric Hospitalizations (Initial Request):

Date	Facility	Physician	TREATMENT	Meds	Response

B. **Medication History** (Initial Request):

Medication	Highest Dosage	From/To	Response
1.			
2.			
3.			
4.			
5.			

IV. PLEASE NOTE: The attending physician must enter adequate documentation in the medical record of the reasons for this alternative treatment option, that all reasonable treatment modalities have been carefully considered, and that the treatment is definitely indicated and is the most appropriate treatment available for this consumer at this time.

Form Completed By: _____ _____

(PRINT NAME) (SIGNATURE) (Date)

I have reviewed this request form and attest to the content and accuracy of information provided:

Attending Physician: _____

(PRINT NAME) (SIGNATURE) (Date)

Please return this completed request form to:

Macomb County Community Mental Health
CHIEF MEDICAL OFFICE
Fax No.: (586) 469-7674