MACOMB COUNTY COMMUNITY MENTAL HEALTH
PRIOR AUTHORIZATION REQUEST FORM –
SPRAVATO or SPECIALTY TREATMENT

(PLEASE TYPE OR PRINT)

Individual's 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

Diagnosis	ICD10 Code #

II. (A). LEVEL OF TREATMENT SERVICE REQUESTED: Type of Specialty Treatment (if applicable):

□ 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 or SPECIALTY TREATMENT DOCUMENTED AND AGREEMENT FROM OUTPATIENT TREATING PSYCHIATRIST:

Outpatient Psychiatrist Name _____ Date Contacted: _____

II. (C) WHEN SPRAVATO or SPECIALTY TREATMENT INITIATED INPATIENT, PLEASE IDENTIFY THE PLAN FOR FOLLOW UP AND/OR CONTINUED TREATMENT OF SPRAVATO or SPECIALTY TREATMENT PATIENTS AFTER DISCHARGE:(Make sure this meets MCCMH 2-022 Policy requirements)

_____

_____

_____

III. (A). DESCRIBE PATIENT'S CURRENT CLINICAL STATUS AND RATIONALE FOR PROPOSED INITIAL (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: _____

h. Other applicable symptoms: _____

Submit completed form to the Chief Medical Office for clinical review. Requests requiring General Fund support will be forwarded for separate funding determination through the Non-Medicaid Workgroup.

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

V. SECTION – MCCMH REVIEW DETERMINATION

A. Clinical Determination (Chief Medical Office)
☐ Meets Medical Necessity Criteria
☐ Does Not Meet Medical Necessity Criteria

Comments: _____
_____

This determination reflects independent clinical review only and does not constitute financial or service authorization.

CMO/Designee Name: _____
Signature: _____ Date: _____

B. Funding Determination (Non-Medicaid Workgroup – if applicable)
☐ Funding Approved
☐ Funding Denied / Not Available

Committee Review Date: _____
Committee Representative: _____

Final authorization for services requiring General Fund support is dependent upon both clinical and funding determinations, as issued through separate review processes.

III. (B). Continuation Requests **ONLY**: PLEASE EXPLAIN RATIONALE FOR REQUEST OF ADDITIONAL TREATMENT AND INDICATE HOW THE EFFECTIVENESS OF

PREVIOUS TREATMENT IS MEASURED (otherwise mark as N/A):

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):

- Psychiatric Hospitalizations (Initial Request):

Date	Facility	Physician	TREATMENT	Meds	Response

• **Medication History** (Initial Request):

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

IV. PLEASE NOTE: The licensed prescriber 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 individual 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:

Licensed Prescriber:_____

(PRINT NAME) (SIGNATURE) (Date)

Please return this completed request form to:

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