

- POLICY:** Psychiatry – Ketamine Utilization Management Medical Policy
- Ketalar™ (ketamine intravenous infusion)
 - Ketamine intravenous infusion

EFFECTIVE DATE: 7/1/2025

REVIEW DATE: 4/28/2025

COVERAGE CRITERIA FOR: All Aspirus Plan

OVERVIEW

Ketamine (Ketalar™) is a nonbarbiturate anesthetic chemically designated dl 2-(0-chlorophenyl)-2-(methylamino) cyclohexanone hydrochloride. It is formulated as a slightly acid (pH 3.5-5.5) sterile solution for intravenous or intramuscular injection in concentrations containing the equivalent of either 10, 50 or 100 mg ketamine base per milliliter and contains not more than 0.1 mg/mL Phemerol® (benzethonium chloride) added as a preservative.¹ It is approved as an anesthetic agent for diagnostic and surgical procedures that do not require skeletal muscle relaxation, for the induction of anesthesia prior to the administration of other general anesthetic agents, and to supplement low-potency agents, such as nitrous oxide.

POLICY STATEMENT

Due to the lack of clinical efficacy data and safety concerns, approval and coverage is not allowed for Ketamine when used for the conditions listed under Conditions Excluded from Coverage section.

An investigational service is a drug, device, treatment, or procedure which does not have sufficient evidence to permit conclusions concerning safety and effectiveness of the service.

Automation: None.

COVERAGE CRITERIA

Prior authorization is not applicable for ketamine infusions. Coverage of Ketamine is appropriate for the following indications:

FDA-Approved Indications

1. Ketamine injection is considered medically necessary and may be covered for the following:
 - a) Anesthesia for diagnostic and surgical procedures that do not require skeletal muscle relaxation
 - b) The induction of anesthesia prior to administration of other general anesthetic agents
 - c) As supplemental anesthesia for low-potency agents, such as nitrous oxide

CONDITIONS EXCLUDED FROM COVERAGE

Coverage of Ketamine is considered investigational for the following uses/indications and is considered excluded/not covered:

1. Coverage is not allowed for circumstances not listed in the Recommended Authorization Criteria.
2. Ketamine injection is investigational, and therefore not proven or medically necessary for the following:
 - A) Psychiatric disorders (including, but not limited to depression, bipolar disorder, and posttraumatic stress disorder)
 - B) Chronic pain (including, but not limited to nonmalignant pain, fibromyalgia, neuropathic pain, Complex Regional Pain Syndrome, Reflex Sympathetic Dystrophy)
 - C) Headaches
3. Criteria will be updated as new published data are available.

REFERENCES

1. Ketalar [prescribing information]. Chestnut Ridge, NY; Par Pharmaceuticals, Inc.; June 2023

HISTORY

Type of Revision	Summary of Changes	Review Date
New Policy	--	4/28/2025
Aspirus P&T Review	Aspirus P&T Review Policy reviewed and approved by Aspirus P&T committee. Annual review process	4/28/2025
Aspirus P&T Review	Policy reviewed and approved by Aspirus P&T committee. Annual review process	09/15/2025