Spravato™ (esketamine) Medication Precertification Request

(All fields must be completed and legible for precertification review.)

Aetna Precertification Notification
Phone: 1-866-752-7021
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Phone: 1-866-503-0857
FAX: 1-844-268-7263

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy, Date of last treatment ____/____/____

Precertification Requested By: ____________ Phone: ________ Fax: ________

A. PATIENT INFORMATION

First Name:	Last Name:	DOB:
Address:	City:	State: ZIP:
Home Phone: Work Phone:	Cell Phone:	Email:

Patient Current Weight: ____ lbs or ____ kgs Patient Height: ____ inches or ____ cms | Allergies:

B. INSURANCE INFORMATION

Aetna Member ID #: ________
Group #: ________
Insured:

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: ________ Carrier Name: ________
Insured:

Medicare: ☐ Yes ☐ No If yes, provide ID #: **Medicaid:** ☐ Yes ☐ No If yes, provide ID #:

C. PRESCRIBER INFORMATION

First Name:	Last Name: *(Check One):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:	City:		State:	ZIP:
Phone: Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:	Office Contact Name:		Phone:	

Specialty *(Check one):* ☐ **Psychiatrist** ☐ **Other**: ________

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: ________
Center Name: ________
☐ Home Infusion Center Phone: ________
Agency Name: ________
☐ Administration code(s) (CPT): ________
Address: ________

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other ________
Name: ________
Address: ________
Phone: ________ Fax: ________
TIN: ________ PIN: ________

E. PRODUCT INFORMATION

Request is for Spravato (esketamine):
Dose: ________ **Frequency:** ________

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.

Primary ICD Code: ☐ ________ **Secondary ICD Code :** ________ **Other ICD Code:** ________

G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.

For ALL Requests (clinical documentation required for all requests):

Please indicate the patient's diagnosis: ☐ Treatment resistant depression ☐ Major Depressive Disorder with acute suicidal ideation or behavior

☐ Yes ☐ No Does the patient have a moderate or severe substance or alcohol use disorder that is currently not being treated or medically managed?

For Initiation Requests (clinical documentation required for all requests):

☐ Yes ☐ No Does the patient have a confirmed diagnosis of severe major depressive disorder?
→ Which of the following applies to the patient's disease? ☐ Single episode ☐ Recurrent episode ☐ None of the above

☐ Yes ☐ No Has the episode(s) been documented by standardized rating scale that reliably measures depressive symptoms?
→ Please indicate the scale used: ☐ Beck Depression Scale (BDI) ☐ Hamilton Depression Rating Scale (HDRS) ☐ Montgomery-Asberg Depression Rating Scale (MADRS) ☐ Other, please explain: ________
Please indicate the score: ____

☐ Yes ☐ No Will the requested drug be prescribed by or in consultation with a psychiatrist?
☐ Yes ☐ No Will the requested drug be administered under the direct supervision of a healthcare provider?
☐ Yes ☐ No Will the patient be monitored by a health care provider for at least 2 hours after administration?
☐ Yes ☐ No Does the patient have major depressive disorder with current suicidal ideation with intent?
☐ Yes ☐ No Does the patient have thoughts, even momentarily, of self-harm with at least some intent or awareness that they may die as a result, or the patient thinks about suicide?
☐ Yes ☐ No Does the patient intend to act on thoughts of killing themselves?
☐ Yes ☐ No Does the prescriber represent that, in the absence of the requested drug, within the next 24 to 48 hours the patient will require confinement in an acute care psychiatric institution?
☐ Yes ☐ No Has the patient experienced an inadequate response to an adequate trial of evidenced based psychotherapy (e.g., cognitive behavioral therapy) during the current depressive episode?

Continued on next page.

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

☐ Yes ☐ No Has the patient experienced an inadequate response with **two** antidepressants (e.g., selective serotonin reuptake inhibitor [SSRI], serotonin-norepinephrine reuptake inhibitor [SNRI], tricyclic antidepressant [TCA], bupropion, mirtazapine) from two different classes during the current depressive episode?

→ Please indicate which of the following **antidepressant agents** were tried:

☐ Wellbutrin/SR/XL (bupropion) ☐ Marplan (isocarboxazid) ☐ Nardil (phenelzine) ☐ Parnate (tranylcypromine)
☐ phenelzine ☐ tranylcypromine ☐ amoxapine ☐ maprotiline ☐ mirtazapine/ODT ☐ Oleptro ER (trazodone)
☐ Remeron/Solutab (mirtazapine) ☐ trazodone ☐ Celexa (citalopram) ☐ citalopram ☐ escitalopram ☐ fluoxetine
☐ fluvoxamine ☐ Lexapro (escitalopram) ☐ Luvox/CR (fluvoxamine) ☐ paroxetine ☐ Paxil/CR (paroxetine)
☐ Pexeva (paroxetine mesylate) ☐ Prozac/Weekly (fluoxetine) ☐ sertraline ☐ Zoloft (sertraline) ☐ Cymbalta (duloxetine)
☐ desvenlafaxine/ER ☐ duloxetine ☐ Effexor/XR (venlafaxine) ☐ Fetzima (levomilnacipran) ☐ Irenka (duloxetine)
☐ Khedezla (desvenlafaxine) ☐ Pristiq (desvenlafaxine) ☐ venlafaxine/ER ☐ amitriptyline ☐ desipramine ☐ doxepin
☐ Elavil (amitriptyline) ☐ imipramine ☐ Norpramin (desipramine) ☐ nortriptyline ☐ Pamelor (nortriptyline)
☐ Surmontil (trimipramine) ☐ Tofranil (imipramine) ☐ trimipramine ☐ Other, please explain: ____________________

Please indicate which of the following **antidepressant medication classes** were tried:

☐ aminoketones (Wellbutrin/SR/XL [bupropion])
☐ monoamine oxidase inhibitors (MAOIs) (e.g., Marplan, Nardil, Parnate, phenelzine, tranylcypromine)
☐ noradrenaline and specific serotoninergic antidepressants (NASSAs) (e.g., amoxapine, maprotiline, mirtazapine/ODT, Oleptro ER, Remeron/Solutab, trazodone)
☐ selective serotonin reuptake inhibitors (SSRIs) (e.g., Celexa, citalopram, escitalopram, fluoxetine, fluvoxamine, Lexapro, Luvox/CR, paroxetine, Paxil/CR, Pexeva, Prozac/Weekly, sertraline, Zoloft)
☐ serotonin-norepinephrine reuptake inhibitors (SNRIs) (e.g., Cymbalta, desvenlafaxine/ER, duloxetine, Effexor/XR, Fetzima, Irenka, Khedezla, Pristiq, venlafaxine/ER)
☐ tricyclic antidepressants (TCAs) (e.g., amitriptyline, desipramine, doxepin, Elavil, imipramine, Norpramin, nortriptyline, Pamelor, Surmontil, Tofranil, trimipramine)
☐ Other, please explain: ____________________

☐ Yes ☐ No Were the prescribed doses at the maximally tolerated labeled dose?

Please indicate the length of the trial with the first agent: __________weeks/months/years

Please indicate the length of the trial with the second agent: __________weeks/months/years

☐ Yes ☐ No Has the patient experienced an inadequate response with an adequate trial of any of the following augmentation therapies during the current depressive episode?

→ Please identify the augmentation therapy:

☐ Two antidepressants with different mechanisms of action used concomitantly
☐ An antidepressant and a second-generation antipsychotic used concomitantly
☐ An antidepressant and lithium used concomitantly ☐ An antidepressant and thyroid hormone used concomitantly
☐ An antidepressant and buspirone used concomitantly ☐ Other, please explain: ____________________

Please indicate the length of the trial of augmentation therapy: __________weeks/months/years

☐ Yes ☐ No Will the requested drug be used in combination with an oral antidepressant (e.g., duloxetine, escitalopram, sertraline, venlafaxine)?

→ Please select: ☐ duloxetine ☐ escitalopram ☐ sertraline ☐ venlafaxine ☐ other, please explain: ____________________

For Continuation Requests (clinical documentation required for all requests):

☐ Yes ☐ No ☐ Unknown Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program?

For treatment resistant depression only:

☐ Yes ☐ No Has there been improvement or sustained improvement from baseline in depressive symptoms documented by standardized rating scales that reliably measure depressive symptoms (e.g., Beck Depression Scale [BDI], Hamilton Depression Rating Scale [HDRS], Montgomery-Asberg Depression Rating Scale [MADRS], etc.)?

→ Please indicate the scale and score: Scale: ____________________ Score: _____

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required)*: ____________________ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.