Spravato™ (esketamine) Medication Precertification Request

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

Aetna Precertification Notification
Phone: 1-866-752-7021 **(TTY:** 711**)**
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Please Use Medicare Request Form

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 #: _____	Does patient have other coverage? ☐ Yes ☐ No
Group #: _____	If yes, provide ID#: _____ Carrier Name: _____
Insured:	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: ☐ Major Depressive Disorder with acute suicidal ideation or behavior ☐ Treatment resistant depression

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

☐ Yes ☐ No Will the requested drug be prescribed by or in consultation with a psychiatrist?

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

For Major Depressive Disorder and Treatment depression:

☐ Yes ☐ No Does the patient have a confirmed diagnosis of severe major depressive disorder (single or recurrent episode), 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.)?

☐ 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 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: _____

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.

Treatment depression

☐ Yes ☐ No Has the patient experienced an inadequate response with **two** antidepressants from at least two different classes (with a different mechanism of action) during the current depressive episode?

Please indicate the therapeutic class for the first antidepressant tried:

☐ Aminoketone (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) ☐ Serotonin modulators (e.g., Trintellix, vortioxetine, Viibryd, vilazodone) ☐ Other, please explain: _____

Please indicate the therapeutic class for the second antidepressant 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) ☐ Serotonin modulators (e.g., Trintellix, vortioxetine, Viibryd, vilazodone) ☐ Other, please explain: _____

☐ Yes ☐ No Was the first antidepressant titrated up to the maximally tolerated labeled dose?

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

☐ Yes ☐ No Was the therapeutic class of the second antidepressant tried different from the class of the first antidepressant tried?

☐ Yes ☐ No Was the second antidepressant titrated up to the maximally tolerated labeled dose?

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 evidenced based psychotherapy (e.g., cognitive behavioral therapy) during the current depressive episode?

→ ☐ 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

Major Depressive Disorder

☐ 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?

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

For treatment resistant depression only:

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

☐ 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.