Spravato (Esketamine) nasal spray treatment: Initial authorization request

Instructions: Please **thoroughly complete** all fields in the treatment request form. Missing information will delay processing as all requested clinical information is needed to determine if medical necessity is met for this treatment. "See attached" is not a sufficient response, as all information on the form needs to be accurate as of the date signed by the provider.

Per policy, Spravato treatment reimbursement is limited to CPT codes G2082-83. Provider reimbursement for Spravato is restricted to the buy-and-bill model. Preauthorization is required.

Please submit this form through provider self-service at **HumanaMilitary.com** to ensure all necessary clinical information is included and to expedite the authorization process.

Date submitted: _____

Beneficiary information

Name: _____ DOB: _____ TRICARE ID: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Phone #: _____

Referring provider

Provider name: _____ TIN/NPI: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Point of contact direct phone #: _____ Fax #: _____

Rendering provider

Provider name: _____ TIN/NPI: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Point of contact direct phone #: _____ Fax #: _____

Provider enrolled/certified in Risk Evaluation and Mitigation Strategy (REMS): ☐ Yes ☐ No

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Initial authorization request (Induction)

Background information

Onset of **current** episode of depression: Month/year _____

Current psychiatric and medical conditions

Diagnosis (DSM-5/ICD-10)	Onset	Description (include symptoms, treatment, etc.)

Current medications

Medication name	Dose	Duration	Efficacy

Evidence based rating scale outcomes over course of Spravato treatment:

Assessment: _____ Score: _____ Date: _____

Assessment: _____ Score: _____ Date: _____

Assessment: _____ Score: _____ Date: _____

Assessment: _____ Score: _____ Date: _____

Assessment: _____ Score: _____ Date: _____

Assessment: _____ Score: _____ Date: _____

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Please list and describe trials of failed antidepressants used during current depressive episode:

Medication name	Dose	Duration (start and stop month/year)	Response to medication

Documented evidence of adherence to treatment: ☐ Yes ☐ No

Please list and describe trials of all other failed antidepressants:

Medication name	Dose	Duration	Response to medication

History of psychotherapy: ☐ Yes ☐ No Date of treatment:_____

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Current or past diagnosis of substance use disorder ☐ Yes ☐ No If yes, please detail, including date of last use _____

_____

History of Spravato nasal spray use? ☐ Yes ☐ No If yes, please describe, including date of last treatment: _____

_____

Service request information

Anticipated start date: _____

Indication of use (select one)

☐ Treatment-Resistant Depression (TRD) in adults. (12 doses over eight weeks)

☐ Major Depressive Disorder (MDD) with acute suicidal ideation or behavior. (eight doses over four weeks)

CPT code	Units	Frequency	Additional comments

Desired observable outcomes: _____

_____

Beneficiary agrees with treatment goals? ☐ Yes ☐ No

Beneficiary will be enrolled in REMS while received Spravato treatment: ☐ Yes ☐ No

Beneficiary will be monitored for at least two hours following administration of Spravato nasal spray by a qualified healthcare provider ☐ Yes ☐ No

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Please respond to the following (mark all that apply):

- ☐ Beneficiary has **not** had vagal nerve stimulation or deep brain stimulation in the current depressive episode
- ☐ Beneficiary has **not** had a full treatment of electroconvulsive therapy (defined as at least seven treatments) in the current depressive episode
- ☐ No aneurysmal vascular disease (including thoracic and abdominal aorta, intracranial, and peripheral arterial vessels)
- ☐ No arteriovenous malformations
- ☐ No history of intracerebral hemorrhage
- ☐ No active psychosis
- ☐ Beneficiary is not pregnant or breast-feedin
- ☐ No history of hypersensitivity to esketamine, ketamine or any of the excipients
- ☐ Transcranial Magnetic Stimulation (TMS) will **not** be administered over the course of Spravato treatment.
- ☐ Spravato will be used in conjunction with an oral antidepressant.

Signature indicates that the beneficiary is physically and intellectually capable to actively participate in all aspects of the therapeutic program and information provided is true and accurate to the best of my knowledge.

Provider signature: _____ Date _____

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