ESKETAMINE/SPRAVATO REQUEST FORM

☐ In Network	☐ Out of Network	
Member Name:	DOB:	Gender:
Health Plan:		Policy #:
Treating Clinician/Facility:		Provider ID #:
Site Address:		
NPI:	TIN:	
Contact:	Phone:	
Fax:	Email:	
Certified in Spravato REMS Program? ☐ Yes ☐ No		
Requested Start Date:	Number of units (in 90 days):	Dose to be administered:

TREATMENT REQUEST

Has a confirmed diagnosis of severe major depressive disorder (MDD)

Diagnosis Code	Description

Primary Medical Diagnosis (if applicable)

Who made the behavioral health diagnosis?

To ensure both pages are for the same individual, Member name and policy #

Documentation of an inadequate response to at least 2 different antidepressants from different classes at an adequate dose, duration, and adherence in the current depressive episode.

Medication	Dose (in mg)	Frequency (times per day)	Duration in weeks
1.			

Was member medication adherent ☐ Yes, at least 80% ☐ No, less than 80%

What rating scale was used to determine inadequate response:

Baseline:	First Follow-up:	Second Follow-up:

2.			

Was member medication adherent ☐ Yes, at least 80% ☐ No, less than 80%

What rating scale was used to determine inadequate response:

Baseline:	First Follow-up:	Second Follow-up:

3.			
4.			
5.			

Augmenting therapies used during this episode (include medication name, dose, frequency, duration)

☐ Second generation anti-psychotic				
☐ Lithium				
☐ Second anti-depressant from a different class				
☐ Thyroid hormone				

☐ Contraindication to all augmentation strategies ☐ No augmenting therapies utilized

Has/ will an oral antidepressant be prescribed as a conjunctive therapy (include name, dose, frequency):
☐ Yes ☐ No

Contraindications (please select from the list below):

☐ Severe hepatic disease (Child-Puch class C)

☐ Hypersensitive to ketamine, esketamine, or any component of the formulation

☐ Aneurysmal vascular disease (including thoracic and abdominal aorta, intracranial, and peripheral arterial vessels)

☐ Arteriovenous malformation

☐ History of intracerebral hemorrhage

MDD with Suicidality (only complete if applicable)

Does member have confirmed suicidal ideation with intent in the last 48 hours based on an evidence based suicide risk assessment tool?

☐ yes ☐ no

What evidence-based tool was used to make this assessment?

Will the first dose be administered in an inpatient setting?: ☐ yes ☐ no

In the last 6 months, has the member had an active substance use disorder, opioid use disorder, or alcohol use disorder? ☐ yes ☐ no