



ESKETAMINE/SPRAVATO REQUEST FORM

Fax: 800.370.1116

<input type="checkbox"/> In Network		<input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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?

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:
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2.			
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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:
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3.			
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4.			
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5.			
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Augmenting therapies used during this episode (include medication name, dose, frequency, duration)

<input type="checkbox"/> Second generation anti-psychotic				
<input type="checkbox"/> Lithium				
<input type="checkbox"/> Second anti-depressant from a different class				
<input type="checkbox"/> 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-Pugh 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