Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Spravato
(esketamine)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication Requested: ICD10:
☐ Spravato 28mg nasal spray
☐ Spravato 56mg dose kit nasal spray
☐ Spravato 84mg does kit nasal spray

Directions for use: Quantity: Duration of therapy:

Is this a new start or continuation of therapy?
☐ new start of therapy
☐ continued therapy

(if continued therapy) Is there a previous approval on record for the medication requested? Yes ☐ No ☐

(if continued therapy) Is there documentation your patient has had a beneficial response (for example, a 50% or greater reduction in a depression rating scale score from baseline) with the requested medication? Yes ☐ No ☐

(if no) Please provide clinical support for continued use of Spravato. Please also note how many doses of Spravato your patient has already received.

Where will this medication be obtained?
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Is the patient a candidate for home infusion? Yes ☐ No ☐
Does the physician have an in-office infusion site? Yes ☐ No ☐

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

What is your patient's diagnosis?
☐ Major Depressive Disorder with Acute Suicidal Ideation or Behavior
☐ Treatment-Resistant Depression
☐ other (please specify):

Clinical Information
****This drug requires supportive documentation (chart notes, lab and test results, etc). Supportive documentation for all answers must be attached with this request****

Is Spravato being prescribed by, or in consultation with, a psychiatrist? Yes ☐ No ☐

Will/Is Spravato be(ing) used with at least ONE oral antidepressant?
Notes: Note: may include, but are not limited to, selective serotonin reuptake inhibitors (SSRIs), serotonin-norepinephrine reuptake inhibitors (SNRIs), tricyclic antidepressants (TCAs), mirtazapine, and bupropion. Selective Serotonin Reuptake Inhibitors [SSRIs] include: Citalopram; Escitalopram; Fluoxetine; Fluvoxamine; Paroxetine; Sertraline. Serotonin-Norepinephrine Reuptake Inhibitors [SNRIs] include: Desvenlafaxine; Duloxetine; Levomilnacipran; Venlafaxine; Tricyclic Antidepressants include: Amitriptyline; Amoxapine; Clomipramine; Desipramine; Doxepin; Imipramine; Nortriptyline; Protriptyline; Trimipramine. Yes ☐ No ☐

Does your patient have a history of psychosis? Yes ☐ No ☐

(if yes) Does the prescriber believe that the benefits of Spravato outweigh the risks? Yes ☐ No ☐

(if Major Depressive Disorder with Acute Suicidal Ideation or Behavior) Does the patient have major depressive disorder that is considered to be severe, according to the prescriber? Yes ☐ No ☐

(if Treatment-Resistant) Has the patient's risk for abuse of controlled substances been assessed (for example, using the state prescription drug monitoring program [PDMP])? Yes ☐ No ☐ Not applicable (Missouri only) ☐

(if Treatment-Resistant) Has your patient previously been treated with any other antidepressants for this condition? (check all that apply.)

☐ Bupropion (Aplenzin, Forfivo XL, Wellbutrin, Wellbutrin SR, Wellbutrin XL)
☐ Mirtazapine (Remeron, Remeron SolTab)
☐ serotonin-norepinephrine reuptake inhibitors (SNRIs) (Desvenlafaxine [Khedezla], Desvenlafaxine succinate [Pristiq], Duloxetine [Cymbalta], Levomilnacipran [Fetzima], Venlafaxine [Effexor XR]
☐ selective serotonin reuptake inhibitors (SSRIs) (Citalopram [Celexa], Escitalopram [Lexapro], Fluoxetine [Prozac], Fluvoxamine, Paroxetine hydrochloride [Paxil, Paxil CR], Paroxetine mesylate [Brisdelle, Pexeva], Sertraline [Zoloft])
☐ tricyclic antidepressants (TCAs) (Amitriptyline [Elavil], Amoxapine, Clomipramine [Anafranil], Desipramine [Norpramin], Doxepin [Silenor], Imipramine [Tofranil, Tofranil-PM], Nortriptyline [Pamelor], Protriptyline, Trimipramine [Sumontil])
☐ No none of the above

(if treated previously with classes above) Please include specific drug name(s) and strength(s), date(s) taken and for how long, and what the documented results were of taking each.

Did the patient demonstrate nonresponse (defined as 25% or less improvement in depression symptoms or scores) to at least TWO different antidepressants, each from a different pharmacologic class? Yes ☐ No ☐

Was each antidepressant used at therapeutic dosages for at least 6 weeks in the current episode of depression? Yes ☐ No ☐

What alternatives have been tried? Please include drug name anddocumented results of taking each drug, including any intolerances or adverse reactions your patient experienced.
Notes: If yes to all questions, please answer as "all yes"

Additional pertinent information (*include alternatives tried, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced*):

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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