Esketamine (Spravato) Request Form

New York | Medicaid

Fill out *completely* to prevent delays. Once finished, submit through our preferred method via https://Availity.com or fax to **844-452-8072**.

Member name:	ID number:
Member DOB:	Current age:
Member address:	Member contact phone:

Requesting Esketamine (Spravato) office information

Physician's name:	NPI/Tax ID:
Office contact name:	Office contact name:
Office address:	

Outpatient practitioner's information

Psychiatrist's name:	Phone number:
Therapist's name:	Phone number:

Procedure code	Number of units	Frequency	Start date

Please select all that apply:

☐ The individual is an adult.
☐The individual has a confirmed diagnosis. ☐Major depressive disorder with depressive symptoms and acute suicidal ideation or behavior confirmed by psychiatrist. or ☐Major depressive disorder with treatment-resistant depression confirmed by psychiatrist.
☐Esketamine (Spravato) is requested for the treatment of a disorder other than severe MDD.

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If checked, please specify the disorder:
☐Diagnosis is confirmed by the psychiatrist listed above. If an alternate provider, please list name and NPI.
The individual will be treated in combination with an oral depressant. ☐Yes ☐No
☐ Treatment trials with ≥ 2 antidepressants for at least [6 weeks] each. ☐Yes ☐No
☐The individual cannot tolerate psychopharmacologic agents as evidenced by ≥ 2 trials with distinct side effects.

☐The individual has had a trial of an evidence-based psychotherapy known to be effective in the treatment of MDD. **If selected,** please mark which of the following apply: ☐The psychotherapy trial had an adequate frequency and duration. ☐The psychotherapy trial did not result in a significant improvement in depressive symptoms.
Choose all that apply for the individual: ☐No history of aneurysmal vascular disease, arteriovenous malformation, or intracranial hemorrhage ☐Monitoring is planned after each administration ☐Risks of sedation and dissociation after administration are discussed with the patient or caregiver ☐Risks of abuse and misuse were discussed with the patient or caregiver ☐Not currently pregnant and risks of pregnancy discussed with patient or caregiver, or pregnancy testing not indicated ☐Not breastfeeding or the risks of breastfeeding have been discussed with the patient or caregiver ☐Other clinical information (add comment):
List all current ICD-10 diagnoses:

Specific focus of treatment for this member

For the current episode of depression, list the medication trials:

Medication antidepressants	Date of trial	Maximum dose	Duration of trial	Outcome, side-effects, other relevant information

Was a standardized rating scale of depression used?

☐Yes ☐No

What were the results (score/range):

Is this a request for continued Esketamine (Spravato) treatment?

☐Yes ☐No

If yes, please respond below:

Select all that apply:

☐Condition improved with treatment

☐Manageable or no side effects

☐Used in combination with an oral antidepressant

☐Other clinical information (add comment)

Additional clinical information to support the above:

You may also submit any additional information relevant to your request for authorization.

By signing below, you confirm that the information provided on this form is accurate and complete based on your clinical assessment of the patient and the records available to you as of the date of this request.

Print MD name:	Date:
Signature:	