Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

Horizon NJ Health
Esketamine (Spravato®) – Medical Necessity Request
*****Complete page 1 for Initial Requests Only*****

Contraindication Information: Please indicate if the member has any of the listed contraindications for the requested drug

□ Aneurysmal vascular disease (including in the brain, chest, abdominal aorta, arms and legs)
□ Arteriovenous malformation
□ History of bleeding in the brain
□ None of the above

General Questions:

1. Will the member use Spravato together with an oral antidepressant therapy? **Yes or No**
2. Will Spravato be administered under the supervision of a healthcare provider and be monitored for at least 2 hours after administration? **Yes or No**
3. Has the member been assessed and determined not to be at risk for abuse and misuse of Spravato? **Yes or No**

Diagnosis Information (please select the diagnosis and answer applicable questions as needed):

□ Treatment-resistant depression? **Yes or No**

a. If yes, does the member have any contraindications to any antidepressants (i.e. sertraline, duloxetine, amitriptyline, etc.)? **Yes or No**

- Please explain the contraindication and to which drug(s):

_____

_____

b. If yes, please document all medications the member has used for the given diagnosis, length of trial and discontinuation reasons.

Drug Name	***Length of trial*** *(e.g., #days, #weeks, #months, #years)*	***Discontinuation Reason***

□ Depressive symptoms in adults with major depressive disorder (MDD) with acute suicidal ideation or behavior
□ Other: _____

Physician office's signature*_____ Print Name_____
***Form must be completed and signed by physician or licensed representative from the physician's office**

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

Horizon NJ Health

Esketamine (Spravato®) – Medical Necessity Request

*****Complete page 2 only for Subsequent/Renewal requests*****

1. Does the member have documented response to therapy demonstrated by an improvement from baseline in the Montgomery-Asberg Depression Rating Scale (MADRS)? **Yes or No**

2. Will the member use Spravato together with an oral antidepressant therapy? **Yes or No**

3. Will Spravato be administered under the supervision of a healthcare provider and be monitored for at least 2 hours after administration? **Yes or No**

4. What is the member's diagnosis?
   - □ Treatment resistant depression
   - □ Major depressive disorder with acute suicidal ideation or behavior
   - □ Other: _____

Physician office's signature*_____ Print Name_____

***Form must be completed and signed by physician or licensed representative from the physician's office**