aetna®

# Spravato™ (esketamine) Medication Precertification Request



(All fields must be completed and legible for precertification review.)

**Aetna Precertification Notification**
**Phone:** 1-866-752-7021
**FAX:** 1-888-267-3277

**For Medicare Advantage Part B:**
**Phone:** 1-866-503-0857
**FAX:** 1-844-268-7263

**Please indicate:** ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy, Date of last treatment ____/____/____

**Precertification Requested By:** _____ Phone: _____ Fax: _____

## A. PATIENT INFORMATION

| | | | | |
|---|---|---|---|---|
| First Name: | Last Name: | | DOB: | |
| Address: | | City: | State: | ZIP: |
| Home Phone: | Work Phone: | Cell Phone: | Email: | |
| Patient Current Weight: _____ lbs or _____ kgs Patient Height: _____ inches or _____ cms | | | Allergies: | |

## B. INSURANCE INFORMATION

**Aetna Member ID #**: _____
**Group #**: _____
**Insured**:

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured:

**Medicare:** ☐ Yes ☐ No If yes, provide ID #: **Medicaid:** ☐ Yes ☐ No If yes, provide ID #:

## C. PRESCRIBER INFORMATION

| | | | | | |
|---|---|---|---|---|---|
| First Name: | | Last Name: | | *(Check One):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A. | |
| Address: | | | City: | State: | ZIP: |
| Phone: | Fax: | St Lic #: | NPI #: | DEA #: | UPIN: |
| Provider Email: | | Office Contact Name: | | Phone: | |

**Specialty** *(Check one):* ☐ **Psychiatrist** ☐ **Other**: _____

## D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

**Place of Administration:**
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

**Dispensing Provider/Pharmacy:** *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other _____
Name: _____
Address: _____
Phone: _____ Fax: _____
**TIN:** _____ PIN: _____

## E. PRODUCT INFORMATION

**Request is for Spravato (esketamine):**
**Dose:** _____ **Frequency:** _____

## F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.

**Primary ICD Code:** ☐ _____ **Secondary ICD Code :** _____ **Other ICD Code:** _____

## G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.

**For ALL Requests (clinical documentation required for all requests):**
Please indicate the patient's diagnosis: ☐ Treatment resistant depression ☐ Major Depressive Disorder with acute suicidal ideation or behavior
☐ Yes ☐ No Does the patient have a moderate or severe substance or alcohol use disorder that is currently not being treated or medically managed?

**For Initiation Requests (clinical documentation required for all requests):**
☐ Yes ☐ No Does the patient have a confirmed diagnosis of severe major depressive disorder?
→ Which of the following applies to the patient's disease? ☐ Single episode ☐ Recurrent episode ☐ None of the above
☐ Yes ☐ No Has the episode(s) been documented by standardized rating scale that reliably measures depressive symptoms?
→ Please indicate the scale used: ☐ Beck Depression Scale (BDI) ☐ Hamilton Depression Rating Scale (HDRS)
☐ Montgomery-Asberg Depression Rating Scale (MADRS) ☐ Other, please explain: _____
Please indicate the score: _____
☐ Yes ☐ No Has the diagnosis been verified by a psychiatrist?
☐ Yes ☐ No Will the requested drug be administered under the direct supervision of a healthcare provider?
☐ Yes ☐ No Will the patient be monitored by a health care provider for at least 2 hours after administration?
☐ Yes ☐ No Does the patient have major depressive disorder with current suicidal ideation with intent?
☐ Yes ☐ No Does the patient have thoughts, even momentarily, of self-harm with at least some intent or awareness that they may die as a result, or the patient thinks about suicide?
☐ Yes ☐ No Does the patient intend to act on thoughts of killing themselves?
☐ Yes ☐ No Does the prescriber represent that, in the absence of the requested drug, within the next 24 to 48 hours the patient will require confinement in an acute care psychiatric institution?
☐ Yes ☐ No Has the patient experienced an inadequate response to an adequate trial of cognitive behavioral therapy during the current depressive episode?

***Continued on next page.***

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| Patient First Name | Patient Last Name | Patient Phone | Patient DOB |
|---|---|---|---|
| | | | |

**G. CLINICAL INFORMATION *(continued)*** – Required clinical information must be completed in its entirety for all precertification requests.

☐ Yes ☐ No Has the patient experienced an inadequate response with **two** antidepressants (e.g., selective serotonin reuptake inhibitor [SSRI], serotonin-norepinephrine reuptake inhibitor [SNRI], tricyclic antidepressant [TCA], bupropion, mirtazapine) from two different classes during the current depressive episode?

→ Please indicate which of the following **antidepressant agents** were tried:

☐ Wellbutrin/SR/XL (bupropion) ☐ Marplan (isocarboxazid) ☐ Nardil (phenelzine) ☐ Parnate (tranylcypromine)
☐ phenelzine ☐ tranylcypromine ☐ amoxapine ☐ maprotiline ☐ mirtazapine/ODT ☐ Oleptro ER (trazodone)
☐ Remeron/Solutab (mirtazapine) ☐ trazodone ☐ Celexa (citalopram) ☐ citalopram ☐ escitalopram ☐ fluoxetine
☐ fluvoxamine ☐ Lexapro (escitalopram) ☐ Luvox/CR (fluvoxamine) ☐ paroxetine ☐ Paxil/CR (paroxetine)
☐ Pexeva (paroxetine mesylate) ☐ Prozac/Weekly (fluoxetine) ☐ sertraline ☐ Zoloft (sertraline) ☐ Cymbalta (duloxetine)
☐ desvenlafaxine/ER ☐ duloxetine ☐ Effexor/XR (venlafaxine) ☐ Fetzima (levomilnacipran) ☐ Irenka (duloxetine)
☐ Khedezla (desvenlafaxine) ☐ Pristiq (desvenlafaxine) ☐ venlafaxine/ER ☐ amitriptyline ☐ desipramine ☐ doxepin
☐ Elavil (amitriptyline) ☐ imipramine ☐ Norpramin (desipramine) ☐ nortriptyline ☐ Pamelor (nortriptyline)
☐ Surmontil (trimipramine) ☐ Tofranil (imipramine) ☐ trimipramine ☐ Other, please explain: _____

Please indicate which of the following **antidepressant medication classes** were tried:

☐ aminoketones (Wellbutrin/SR/XL [bupropion])
☐ monoamine oxidase inhibitors (MAOIs) (e.g., Marplan, Nardil, Parnate, phenelzine, tranylcypromine)
☐ noradrenaline and specific serotoninergic antidepressants (NASSAs) (e.g., amoxapine, maprotiline, mirtazapine/ODT, Oleptro ER, Remeron/Solutab, trazodone)
☐ selective serotonin reuptake inhibitors (SSRIs) (e.g., Celexa, citalopram, escitalopram, fluoxetine, fluvoxamine, Lexapro, Luvox/CR, paroxetine, Paxil/CR, Pexeva, Prozac/Weekly, sertraline, Zoloft)
☐ serotonin-norepinephrine reuptake inhibitors (SNRIs) (e.g., Cymbalta, desvenlafaxine/ER, duloxetine, Effexor/XR, Fetzima, Irenka, Khedezla, Pristiq, venlafaxine/ER)
☐ tricyclic antidepressants (TCAs) (e.g., amitriptyline, desipramine, doxepin, Elavil, imipramine, Norpramin, nortriptyline, Pamelor, Surmontil, Tofranil, trimipramine)
☐ Other, please explain: _____

☐ Yes ☐ No Were the prescribed doses at the maximally tolerated labeled dose?

Please indicate the length of the trial with the first agent: _____weeks/months/years

Please indicate the length of the trial with the second agent: _____weeks/months/years

☐ Yes ☐ No Has the patient experienced an inadequate response with an adequate trial of any of the following augmentation therapies during the current depressive episode?

→ Please identify the augmentation therapy:

☐ Two antidepressants with different mechanisms of action used concomitantly
☐ An antidepressant and a second-generation antipsychotic used concomitantly
☐ An antidepressant and lithium used concomitantly ☐ An antidepressant and thyroid hormone used concomitantly
☐ An antidepressant and buspirone used concomitantly ☐ Other, please explain: _____

Please indicate the length of the trial of augmentation therapy: _____weeks/months/years

☐ Yes ☐ No Will the requested drug be used in combination with an oral antidepressant (e.g., duloxetine, escitalopram, sertraline, venlafaxine)?

→ Please select: ☐ duloxetine ☐ escitalopram ☐ sertraline ☐ venlafaxine ☐ other, please explain: _____

**For Continuation Requests (clinical documentation required for all requests):**

☐ Yes ☐ No ☐ Unknown Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program?

For treatment resistant depression only:

☐ Yes ☐ No Has there been improvement or sustained improvement from baseline in depressive symptoms documented by standardized rating scales that reliably measure depressive symptoms (e.g., Beck Depression Scale [BDI], Hamilton Depression Rating Scale [HDRS], Montgomery-Asberg Depression Rating Scale [MADRS], etc.)?

→ Please indicate the scale and score: Scale: _____ Score: _____

**H. ACKNOWLEDGEMENT**

**Request Completed By *(Signature Required):*** _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.