

# Spravato (Esketamine) continued request

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Instructions: Please **thoroughly complete** all fields in the treatment request form. Missing information will delay processing as all requested clinical information is needed to determine if medical necessity is met for this treatment. "See attached" is not a sufficient response, as all information on form needs to be accurate as of the date signed by the provider.

Please submit this form through provider self-service at **HumanaMilitary.com** to ensure all necessary clinical information is included and to expedite the authorization process.

Date submitted: \_\_\_\_\_

## Beneficiary information

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ TRICARE ID: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Phone #: \_\_\_\_\_

## Rendering provider

Provider name: \_\_\_\_\_ TIN/NPI: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Point of contact direct phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Provider enrolled/certified in Risk Evaluation and Mitigation Strategy (REMS):  Yes  No

Who will be billing TRICARE for the drug (Spravato/ Esketamine nasal spray)?

Rendering provider (buy and bill) or  Specialty pharmacy

If pharmacy, the following information is required:

Pharmacy name: \_\_\_\_\_ TIN/NPI: \_\_\_\_\_

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## Current psychiatric and medical conditions

Diagnosis (DSM-5/ICD-10)	Onset	Description (include symptoms, treatment, etc.)

## Current medications

Medication name	Dose	Duration	Efficacy

Spravato will be used in conjunction with an oral antidepressant:  Yes  No

Please detail any medication changes made since initial Spravato treatment:

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Have there been any suicide attempts since initial Spravato treatment?  Yes  No

If yes, please provide further details: \_\_\_\_\_

\_\_\_\_\_

Clinical progress summary supporting ongoing Spravato treatment:

\_\_\_\_\_

\_\_\_\_\_

Evidence based rating scale outcomes over course of Spravato treatment:

Assessment: \_\_\_\_\_ Score: \_\_\_\_\_ Date: \_\_\_\_\_

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Beneficiary will be enrolled in REMS while receiving Spravato treatment:  Yes  No

Beneficiary will be monitored for at least two hours following administration of Spravato (Esketamine) nasal spray by a qualified healthcare provider:  Yes  No

There are no contraindications to the continuation of treatment with Spravato:  Yes  No

Signature indicates that the beneficiary is physically and intellectually capable to actively participate in all aspects of the therapeutic program and information provided is true and accurate to the best of my knowledge.

Provider signature: \_\_\_\_\_ Date \_\_\_\_\_

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