# Spravato (Esketamine) continued request

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: _____

Assessment: _____ Score: _____ Date: _____

Assessment: _____ Score: _____ Date: _____

Assessment: _____ Score: _____ Date: _____

Assessment: _____ Score: _____ Date: _____

Assessment: _____ Score: _____ Date: _____

Assessment: _____ Score: _____ Date: _____

Assessment: _____ Score: _____ Date: _____

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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