Spravato (Esketamine) continued request

Per policy, Spravato treatment reimbursement is limited to CPT codes G2082-83. Provider reimbursement for Spravato is restricted to buy-and-bill model. Preauthorization is required.

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 the 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

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Spravato (Esketamine) continued request

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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Spravato (Esketamine) continued request

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

If yes, please provide further details: _____

_____

_____

Detailed clinical progress summary supporting ongoing Spravato treatment (Including number of Spravato treatments to date, details of clinical response to treatment, specified impact on symptoms and functioning, dosing plan):

_____

_____

_____

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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