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

Diagnosis Information (please indicate the diagnosis and answer the related questions):

□ Treatment-resistant depression

1. Does the member have any contraindications to any antidepressants (i.e. sertraline, duloxetine, amitriptyline, etc.)? **Yes or No**
- If yes, please explain the contraindication and to which drug(s):

_____
_____
_____

2. Please document all medications the member has used for the given diagnosis, length of trial and discontinuation reasons.
Please also submit documentation of fills and any intolerances experienced.

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

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

□ 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*****

Diagnosis Information (please indicate the diagnosis and answer the related questions):

□ Treatment-resistant depression

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**

□ Other: _____

Physician office's signature*_____ Print Name_____

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