Cigna®

Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Spravato
(esketamine)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication Requested: ICD10:
☐ Spravato 28mg nasal spray
☐ Spravato 56mg dose kit nasal spray
☐ Spravato 84mg does kit nasal spray

Directions for use: Quantity: Duration of therapy:

Is this a new start or continuation of therapy?
☐ new start of therapy
☐ continued therapy

(if continued therapy) Is there a previous approval on record for the medication requested? Yes ☐ No ☐

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ CVS Caremark
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor

**Cigna's nationally preferred specialty pharmacy

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Is the patient a candidate for home infusion? Yes ☐ No ☐

Does the physician have an in-office infusion site? Yes ☐ No ☐

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

What is your patient's diagnosis?

☐ Major Depressive Disorder with Acute Suicidal Ideation or Behavior
☐ Treatment-Resistant Depression
☐ other (please specify):

Clinical Information

Documentation is required for use of Spravato as noted in the criteria. Documentation may include, but is not limited to chart notes, laboratory tests, claims records, and/or other information.

Is the requested medication being prescribed by a psychiatrist? Yes ☐ No ☐

Does your patient have a history of psychosis? Yes ☐ No ☐

(if yes) Does the prescriber believe that the benefits of Spravato outweigh the risks? Yes ☐ No ☐

(if Major Depressive Disorder with Acute Suicidal Ideation or Behavior) Is documentation being provided that the patient is concomitantly receiving at least one oral antidepressant?
Note: may include, but are not limited to, selective serotonin reuptake inhibitors (SSRIs), serotonin-norepinephrine reuptake inhibitors (SNRIs), tricyclic antidepressants (TCAs), mirtazapine, and bupropion. Please note: Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, and/or other information. Medical documentation specific to your response to this question must be attached to this case or your request could be denied Yes ☐ No ☐

(if Major Depressive Disorder with Acute Suicidal Ideation or Behavior) Is documentation being provided that the patient has major depressive disorder that is considered to be severe, according to the prescriber? Please note: Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, and/or other information. Medical documentation specific to your response to this question must be attached to this case or your request could be denied. Yes ☐ No ☐

Is documentation being provided that the patient has demonstrated nonresponse (defined as 25% or less improvement in depression symptoms or scores) to at least TWO different antidepressants, each from a different pharmacologic class?
Notes: Different pharmacologic classes of antidepressants include selective serotonin reuptake inhibitors (SSRIs), serotonin-norepinephrine reuptake inhibitors (SNRIs), tricyclic antidepressants (TCAs), mirtazapine, and bupropion. Please note: Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, and/or other information. Medical documentation specific to your response to this question must be attached to this case or your request could be denied.
Yes ☐ No ☐

Is documentation being provided that each antidepressant was used at therapeutic dosages for at least 6 weeks in the current episode of depression? Please note: Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, and/or other information. Medical documentation specific to your response to this question must be attached to this case or your request could be denied.? Yes ☐ No ☐

(if Treatment-Resistant) Has the patient's history of controlled substance prescriptions been checked using the state prescription drug monitoring program (PDMP), according to the prescriber? Yes ☐ No ☐

Additional pertinent information (*include alternatives tried, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced*):

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

Save Time! Submit Online at: www.covermymeds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.

Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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