BlueCross BlueShield
Federal Employee Program

SPRAVATO
PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Spravato (esketamine)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑Brand ❑Generic

1. Has the patient been on this medication continuously for the **last month** excluding samples? ***Please select answer below:***
   - ❑**NO** – this is **INITIATION** of therapy, please answer the following questions:
     - a. What is the patient's diagnosis?
       - ❑Major depressive disorder (MDD) with acute suicidal ideation or behavior
         - i. Will the medication be used in conjunction with an oral antidepressant? ❑Yes ❑No
         - ii. Will the patient need more than 8 kits for 28 days (4 weeks)? ❑Yes* ❑No
           If YES, please specify the requested quantity: _____ kit(s) for 28 days (4 weeks)
       - ❑Treatment-resistant depression (TRD)
         - i. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least **TWO** different antidepressants? ❑Yes ❑No
         - ii. Will the patient need more than 12 kits for 56 days (8 weeks)? ❑Yes* ❑No
           If YES, please specify the requested quantity: _____ kit(s) for 56 days (8 weeks)
       - ❑Other ***(please specify)***: _____
         - i. How many kits will the patient need for 28 days (4 weeks)? _____ kit(s) for 28 days (4 weeks)
     - b. Was the patient's depression diagnosed using an approved scoring tool, such as the PHQ-9? ❑Yes ❑No
       ***https://www.mdcalc.com/phq-9-patient-health-questionnaire-9**
     - c. Is the healthcare setting, pharmacy, and patient registered with the REMS program? ❑Yes ❑No
   - ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:
     - a. What is the patient's diagnosis?
       - ❑Major depressive disorder (MDD) with acute suicidal ideation or behavior
         - i. Will the medication be used in conjunction with an oral antidepressant? ❑Yes ❑No
       - ❑Treatment-resistant depression (TRD)
       - ❑Other ***(please specify)***: _____
     - b. Has the patient been evaluated for a positive response to therapy? ❑Yes ❑No
     - c. How many kits will the patient need every 84 days (12 weeks)? _____ kit(s) every 84 days (12 weeks)
2. Will this medication be administered under the supervision of a healthcare provider? ❑Yes ❑No
3. Will the patient's blood pressure be assessed prior to and after each administration? ❑Yes ❑No
4. Does the prescriber agree to monitor the patient for sedation, dissociation, and respiratory depression for at least two hours after each administration? ❑Yes ❑No
5. Does the prescriber agree to monitor the patient for clinical worsening and emergence of suicidal thoughts and behaviors? ❑Yes ❑No
6. **FEMALE Patient**: Is the patient pregnant or of reproductive potential? ❑Yes* ❑No
   If YES, does the prescriber agree to advise the patient about the risks for fetal harm? ❑Yes ❑No