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

ICD10:

Directions for use: Quantity: Duration of therapy:

Is this a new start or reauthorization of therapy with the requested medication?
☐ New start
☐ Reauthorization of therapy

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 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 the patient's diagnosis?

☐ Major Depressive Disorder with Acute Suicidal Ideation or Behavior
☐ Treatment-Resistant Depression
☐ Other

Clinical Information

Is the requested medication being prescribed by or in consultation with a psychiatrist or a mental health provider? Yes ☐ No ☐

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

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

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

(if Treatment-Resistant Depression) Is documentation being provided that the patient 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? Note: Different pharmacologic classes of antidepressants include selective serotonin reuptake inhibitors (SSRIs), serotonin-norepinephrine reuptake inhibitors (SNRIs), tricyclic antidepressants (TCAs), bupropion, mirtazapine, etc. PLEASE NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied. Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, and/or other information. All documentation must include patient-specific identifying information. Yes ☐ No ☐

(if Treatment-Resistant Depression) Was each antidepressant used at therapeutic dosages for at least 6 weeks in the current episode of depression, according to the prescriber? Yes ☐ No ☐

(if Treatment-Resistant Depression) 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:

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:**____________________

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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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