

esketamine (Spravato®) Nasal Spray
INTRANASAL SPRAY FOR ADMINISTRATION UNDER SUPERVISION OF A HEALTHCARE PROFESSIONAL

PRIOR REVIEW/CERTIFICATION REQUEST FOR SERVICES FORM

INCOMPLETE FORMS MAY DELAY PROCESSING ALL NC PROVIDERS MUST PROVIDE THEIR 5-DIGIT Blue Cross NC PROVIDER ID# BELOW

PATIENT NAME		BLUE CROSS NO	C MEMBER ID NUMBER	P	ATIENT DATE	OF BIRT	Н
REQUESTING PROVIDER INFORMATION			SERVICING PROVIDER OR FACILITY LOCATION (for services to be performed outside of the physician office)				
Provider Name			Servicing Provider				,
Provider #, Tax ID # or NPI			Facility Name				
Street, Bldg., Suite #			Servicing provider or Facility #, or NPI #				
City/State/Zip code			Street, Bldg., Suite #				
Phone #			City/State/Zip code				
Fax #							
PLACE OF SERVICE:	☐ Home Infusion ☐ Offi	ce □ Outpatient l	· · · · · · · · · · · · · · · · · · ·				
Specialty Pharmacy: HCPCS CODE: □ S0013 □ G2082 □ G2083 CPT/Other billing code:							
	013 □ G2082 □ G2083			:			
Primary Diagnosis:			ICD-10:				
Drug Requested:	1						
Strength & Route of Ac	iministration:						
Please answer the following questions for INITIAL coverage: *See page 3 for continuation coverage; see page 4 for quantity limit exceptions*							
-	ed medication be billed omplete the Spravato						□ No
2. Is the patient 18	Byears of age or older?	?				□ Yes	□ No
· ·	been diagnosed with t		tant depression (TR	(D)?		.□ Yes	□ No
a. Does the	If YES, please answer the following questions: a. Does the patient have a confirmed diagnosis of major depressive disorder (MDD)?□ Yes □ No If YES, please answer the following questions:						
	Does the patient have a	• .				ПУеѕ	□ No
	 If YES, has the dura 						
	Does the patient have r	•					□ No
b. In the current depressive episode, has the patient had an inadequate response							
(≤ 25% i	mprovement) to at least	st two different of	oral antidepressants,	from a	t least two		
different	classes (e.g., SSRIs,	SNRIs, TCAs, b	oupropion, mirtazapin	e, etc.)	, of adequa	ate	
dose an	d duration (typically 6 v	weeks)?				□ Yes	□ No
***COI	ntinued on page 2; pleas	e complete and s	ign page 2 for prior auti	horizati	on request**	r*	

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esketamine (Spravato®) Nasal Spray - continued

•	or bel	he patient been diagnosed with major depressive disorder (MDD) with some view of the following questions:		□ No
	a.	Is the suicidal ideation and intent imminent and warrant potential hospital Will the patient receive this medication in conjunction with an oral antide	pressant	□ No
		medication?	☐ Yes	□ No
,	sever	iation of esketamine nasal spray therapy, does/did the patient have a depr ity of ≥ 28 on the Montgomery-Asberg Depression Rating Scale (MADRS), comparable standardized rating scale that reliably measures depressive sy	or as scored	□ No
(ne patient receive esketamine nasal spray in combination with ketamine, or lation or route of administration, for the same indication?		□ No
		the patient have any clinical contraindications to esketamine nasal spray taneurysmal vascular disease or intracerebral hemorrhage)?		□ No
į	8. Is the	prescriber a specialist in the area of the patient's diagnosis (i.e., psychiatr	ist)?	□No
•		ne requested medication be administered under direct supervision of a heareatment facility that is certified through the Spravato (esketamine) REMS		□ No
		requested quantity within the maximum units allowed (see table on page somplete page 4 for a quantity limit exception.	5)?	□ No
	I certify to further construction Blue Crop further under the records, available		ded. I understand that ify this information. I my patient's medical ny other remedies	
	Prescri	ber's Signature (Required):	Date:	

For Blue Cross NC members, fax form to 1-888-348-7332

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esketamine (Spravato®) Nasal Spray - CONTINUATION

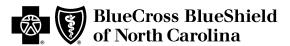
INTRANASAL SPRAY FOR ADMINISTRATION UNDER SUPERVISION OF A HEALTHCARE PROFESSIONAL PRIOR REVIEW/CERTIFICATION REQUEST FOR SERVICES FORM

PATIENT NAME		BLUE CROSS NO	MEMBER ID NUMBER		PATIENT DATE OF	F BIRTH	
REQUESTING PROVIDER INFORMATION SERVICING PROVIDER OR FACILITY LOCATION (for services to be performed outside of the physician office)					office)		
Provider Name			Servicing Provider				
Provider #, Tax ID # Facility Name							
Street, Bldg., Suite #			Servicing provider or Facility #, or NPI #				
City/State/Zip code			Street, Bldg., Suite #				
Phone #			City/State/Zip code				
Fax #							
PLACE OF SERVICE:	☐ Home Infusion ☐ Of	fice □ Outpatien	t hospital □ Specialty	Pharma	асу		
Specialty Pharmacy:			Specialty Pharmacy N				
HCPCS CODE: □ S00)13 □ G2082 □ G2083		CPT/Other billing code	e :			
Primary Diagnosis:			ICD-10:				
Please answer the fo	ollowing questions for	CONTINUATION	coverage:				
	pproved for initial covera					□ Yes	□ No
	swer all questions on p						
•	d medication be billed via					.⊔ Yes	□ No
· •	mplete the Spravato – N			•		□ Voc	□ No
 3. Does the patient have a diagnosis of treatment-resistant depression (TRD)?							
•		•	•			□ Yes	□ No
	rill the patient continue th						
requested	d medication?					□ Yes	□ No
_	S scale or a comparable		-		•		
• •	ne patient demonstrated a		-		•		
	on esketamine nasal spr						□ No
	ceive esketamine nasal						⊐ No
of administration, for the same indication? □ Yes □ No 7. Does the patient have any clinical contraindications to esketamine therapy (i.e., aneurysmal vascular							
disease or intracerebral hemorrhage)?□ Yes □ No							
	prescribed by or in cons						
9. Will the requested medication be administered under direct supervision of a healthcare professional							
					□ No		
10. Is the requested quantity within the maximum units allowed (see table on page 5)?							
If NO, please complete page 4 for a quantity limit exception.							
Please certify the following by signing and dating below: I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that							
my patient's medical records accurately reflect the information provided. I understand that Blue Cross NC may request medical							
records for this patient	at any time in order to verif	fy this information.	I further understand that	if Blue	Cross NC determin	nes this	
pursue any other reme	cted in my patient's medica	records, Blue Cro	ss NC may request a refu	ind of a	any payments made	e and/or	
Prescriber's Signat			Da	te:			

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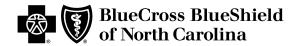
esketamine (Spravato®) Nasal Spray - QUANTITY LIMIT EXCEPTION INTRANASAL SPRAY FOR ADMINISTRATION UNDER SUPERVISION OF A HEALTHCARE PROFESSIONAL

PATIENT NAME		BLUE CROSS NO	C MEMBER ID NUMBER	PATIENT DATE OF BIRTH	
REQUESTING PROVIDER INFORMATION				R OR FACILITY LOCATION formed outside of the physician office)	
Provider Name			Servicing Provider	,	
Provider #, Tax ID # or NPI			Facility Name		
Street, Bldg., Suite #			Servicing provider or Facility #, or NPI #		
City/State/Zip code			Street, Bldg., Suite #		
Phone #			City/State/Zip code		
Fax #					
PLACE OF SERVICE:	☐ Home Infusion ☐ Offi	ce □ Outpatient	hospital ☐ Specialty Ph	armacy	
Specialty Pharmacy:			Specialty Pharmacy N	PI:	
	013 □ G2082 □ G2083		CPT/Other billing code):	
Primary Diagnosis: ICD-10:					
Drug Requested:					
Strength & Route of Ac	Iministration:				
FOR COVERAGE OVER THE FDA LABELED DOSING (SEE TABLE ON PAGE 5), PLEASE ANSWER THE FOLLOWING: Please note: This medication requires a prior authorization before a quantity limit override can be considered. Before submitting a request for a quantity level override, please ensure that a prior approval authorization has been submitted and/or approved (pages 1-2 or page 3). Otherwise, this request will deny. Requested units:					
Please enter quanti	ty as a numeric value wit	th one decimal pla	ace (ex. 1.0, 1.5)*		
In the space provided, please document support for the requested Quantity Limit Exception (this may include documented clinical rationale and/or medical records).					
Please certify the following by signing and dating below: I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that Blue Cross NC may request medical records for this patient at any time in order to verify this information. I further understand that if Blue Cross NC determines this information is not reflected in my patient's medical records, Blue Cross NC may request a refund of any payments made and/or pursue any other remedies available. Prescriber's Signature (Required):					

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esketamine (Spravato®) Nasal Spray - QUANTITY LIMITS INTRANASAL SPRAY FOR ADMINISTRATION UNDER SUPERVISION OF A HEALTHCARE PROFESSIONAL

	FD/	A Label Reference		
Medication	Indication	Dosing [^]	HCPCS	Maximum Units*
esketamine (Spravato®) nasal spray	Treatment Resistant Depression (TRD)	Induction (Weeks 1-4): Twice weekly starting Day 1 with 56mg dose, may increase to 84mg subsequently Maintenance (Weeks 5-8): Once weekly (56mg or 84mg) Maintenance (Weeks 9 and after): Administer every 2 weeks or once weekly (56mg or 84mg)	S0013 G2082** G2083**	Initial: 2,016 Continuation: 4,032
	disorder (MDD) with acute	84 mg twice per week for 4 weeks, may be reduced to 56mg twice per week based on tolerability		

^{*}Maximum units allowed for duration of approval

- **Please note the following applicable HCPCS codes:
 - G2082 Office or other outpatient visit for the evaluation and management of an established patient that requires the supervision of a physician or other qualified healthcare professional and provision of up to 56 mg of esketamine nasal self-administration, includes 2 hours post-administration observation
 - G2083 Office or other outpatient visit for the evaluation and management of an established patient that requires the supervision of a physician or other qualified healthcare professional and provision of greater than 56 mg of esketamine nasal self-administration, includes 2 hours post-administration observation
 - For requests where the drug is supplied/dispensed AND administered with monitoring at the same site, only G codes combining both the drug and service should be submitted (i.e., G2082 or G2083)
 - For requests where the drug is supplied/dispensed by a different site (e.g., specialty pharmacy) than where the drug is administered with monitoring (e.g., physician office), separate codes for the drug and service should be submitted (i.e., S0013 and the most appropriate E/M CPT code for the service)

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