BlueCross BlueShield of North Carolina

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 NC MEMBER ID NUMBER	PATIENT DATE OF BIRTH

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 ☐ Office ☐ Outpatient hospital ☐ Specialty Pharmacy

Specialty Pharmacy:	**Specialty Pharmacy NPI:**
HCPCS CODE: ☐ S0013 ☐ G2082 ☐ G2083	**CPT/Other billing code:**
Primary Diagnosis:	**ICD-10:**
Drug Requested:	
Strength & Route of Administration:	

Please answer the following questions for INITIAL coverage:

*See page 3 for continuation coverage; see page 4 for quantity limit exceptions**

1. Will the requested medication be billed via medical benefits?.....☐ Yes ☐ No
   If NO, please complete the Spravato – NC Standard form to request pharmacy benefits.
2. Is the patient 18 years of age or older?.....☐ Yes ☐ No
3. Has the patient been diagnosed with **treatment-resistant depression** (TRD)?.....☐ Yes ☐ No
   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:
      i. Does the patient have a diagnosis of single-episode MDD?.....☐ Yes ☐ No
         1. **If YES,** has the duration been ≥ 2 years?.....☐ Yes ☐ No
      ii. Does the patient have recurrent MDD without psychotic features?.....☐ Yes ☐ No
   b. In the current depressive episode, has the patient had an inadequate response (≤ 25% improvement) to at least two different oral antidepressants, from at least two different classes (e.g., SSRIs, SNRIs, TCAs, bupropion, mirtazapine, etc.), of adequate dose and duration (typically 6 weeks)?.....☐ Yes ☐ No

continued on page 2; please complete and sign page 2 for prior authorization request

esketamine (Spravato®) Nasal Spray - *continued*

4. Has the patient been diagnosed with **major depressive disorder (MDD)** with suicidal ideation or behavior?.....☐ Yes ☐ No
   If YES, please answer the following questions:
   a. Is the suicidal ideation and intent imminent and warrant potential hospitalization?.....☐ Yes ☐ No
   b. Will the patient receive this medication in conjunction with an oral antidepressant medication?.....☐ Yes ☐ No
5. At initiation of esketamine nasal spray therapy, does/did the patient have a depression symptom severity of ≥ 28 on the Montgomery-Asberg Depression Rating Scale (MADRS), or as scored by a comparable standardized rating scale that reliably measures depressive symptoms?.....☐ Yes ☐ No
6. Will the patient receive esketamine nasal spray in combination with ketamine, of any formulation or route of administration, for the same indication?.....☐ Yes ☐ No
7. Does the patient have any clinical contraindications to esketamine nasal spray therapy (i.e., aneurysmal vascular disease or intracerebral hemorrhage)?.....☐ Yes ☐ No
8. Is the prescriber a specialist in the area of the patient's diagnosis (i.e., psychiatrist)?.....☐ Yes ☐ No
9. Will the requested medication be administered under direct supervision of a healthcare professional at a treatment facility that is certified through the Spravato (esketamine) REMS program?.....☐ Yes ☐ No
10. Is the requested quantity within the maximum units allowed (see table on page 5)?.....☐ Yes ☐ No
    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 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):_____ **Date**:_____

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

BlueCross BlueShield of North Carolina

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 NC MEMBER ID NUMBER	PATIENT DATE OF BIRTH

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 ☐ Office ☐ Outpatient hospital ☐ Specialty Pharmacy

Specialty Pharmacy:	**Specialty Pharmacy NPI:**
HCPCS CODE: ☐ S0013 ☐ G2082 ☐ G2083	**CPT/Other billing code:**
Primary Diagnosis:	**ICD-10:**

Please answer the following questions for CONTINUATION coverage:

1. Was the patient approved for initial coverage for the requested medication through Blue Cross NC?.....☐ Yes ☐ No
   If NO, please answer all questions on pages 1-2. If YES, please answer the following questions:
2. Will the requested medication be billed via medical benefits?.....☐ Yes ☐ No
   If NO, please complete the Spravato – NC Standard form to request pharmacy benefits.
3. Does the patient have a diagnosis of **treatment-resistant depression (TRD)**?.....☐ Yes ☐ No
4. Does the patient have a diagnosis of **major depressive disorder (MDD)** with suicidal ideation or behavior?.....☐ Yes ☐ No
   a. **If YES,** will the patient continue therapy with an oral antidepressant agent in conjunction with the requested medication?.....☐ Yes ☐ No
5. Using the MADRS scale or a comparable standardized rating scale that reliably measures depressive symptoms, has the patient demonstrated at least a 50% reduction in depressive symptoms compared to baseline while on esketamine nasal spray therapy?.....☐ Yes ☐ No
6. Will the patient receive esketamine nasal spray in combination with ketamine, of any formulation or route 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
8. Is this medication prescribed by or in consultation with a psychiatrist?.....☐ Yes ☐ No
9. Will the requested medication be administered under direct supervision of a healthcare professional at a treatment facility that is certified through the Spravato (esketamine) REMS program?.....☐ Yes ☐ No
10. Is the requested quantity within the maximum units allowed (see table on page 5)?.....☐ Yes ☐ No
    If NO, please complete page 4 for a quantity limit exception.

Please certify the following by signing and dating below:
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Prescriber's Signature (Required):_____ **Date**:_____

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

BlueCross BlueShield of North Carolina

esketamine (Spravato®) Nasal Spray - QUANTITY LIMIT EXCEPTION

INTRANASAL SPRAY FOR ADMINISTRATION UNDER SUPERVISION OF A HEALTHCARE PROFESSIONAL

PATIENT NAME	BLUE CROSS NC MEMBER ID NUMBER	PATIENT DATE OF BIRTH

REQUESTING PROVIDER INFORMATION		SERVICING PROVIDER OR FACILITY LOCATION (for services to be performed outside of the physician office)	
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City/State/Zip code		**Street, Bldg., Suite #**	
Phone #		**City/State/Zip code**	
Fax #			

PLACE OF SERVICE: ☐ Home Infusion ☐ Office ☐ Outpatient hospital ☐ Specialty Pharmacy

Specialty Pharmacy:	**Specialty Pharmacy NPI:**
HCPCS CODE: ☐ S0013 ☐ G2082 ☐ G2083	**CPT/Other billing code:**
Primary Diagnosis:	**ICD-10:**
Drug Requested:	
Strength & Route of Administration:	

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 quantity as a numeric value with one decimal place (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):_____ **Date**:_____

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esketamine (Spravato®) Nasal Spray - QUANTITY LIMITS

INTRANASAL SPRAY FOR ADMINISTRATION UNDER SUPERVISION OF A HEALTHCARE PROFESSIONAL

FDA 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**
	Depressive symptoms in adults with major depressive disorder (MDD) with acute suicidal ideation or behavior	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)