**Claim Submission**

**For Pharmacy and Medical billing:**

* Claim processing may be delayed if the information submitted in this worksheet is illegible.
* If the worksheet is left blank or information is missing the claim will be rejected for not enough documentation and reimbursement will be delayed.

**For Medical billing only:**

* A claim should not be submitted until the drug has been administered to the patient.

# Enrollee Information

**Enrollee Last Name: Enrollee First Name:**

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**Date of Birth (MM/DD/YYYY): Enrollee Medicaid ID (2 letters, 5 numbers, 1 letter):**

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**Address:**

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**City, Town or Post Office: State: ZIP Code:**

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# Prescriber Information

**Prescriber Last Name: Prescriber First Name:**

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**National Provider Identifier (NPI) Number:**

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**Preferred Contact (Telephone Number)**

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**Preferred Contact (FAX Number)**

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**Enrollee Last Name: Enrollee First Name:**

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# Clinical Criteria – Drug Information

**Drug Administration:**

Provide the date of drug administration (MM/DD/YYYY):

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Provide the expiration date of the drug if the invoice date is greater than 6 months from the date of drug administration (MM/DD/YYYY):

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**Drug Name and Strength:**

Spravato 56 mg Dose Kit: Two 28 mg nasal spray devices

Spravato 84 mg Dose Kit: Three 28 mg nasal spray devices

**Directions:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Quantity:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Refills (up to 5):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Initiation of Therapy:**  Yes  No

Date therapy initiated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Continuation of Therapy:**  Yes  No

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# Clinical Criteria – Diagnosis

1. Treatment-resistant depression (TRD) OR

Depressive symptoms associated with acute suicidal ideation or behavior

**Enrollee Last Name: Enrollee First Name:**

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# Clinical Criteria – Initiation of Therapy

1. Before initiating esketamine nasal therapy, was a baseline score on a depression assessment tool (e.g., 17-item Hamilton Rating Scale for Depression [HAMD17], 16-item Quick Inventory of Depressive Symptomatology [QIDS-C16], 10-item Montgomery-Asberg Depression Rating Scale [MADRS]) obtained?

Yes  No

1. Has the healthcare outpatient site and the patient been enrolled in the Spravato Risk Evaluation and Mitigation Strategy *(*REMS*)*?

Yes  No

1. Before prescribing esketamine nasal spray was the New York State Prescription Monitoring Program reviewed?

Yes  No

1. For the initial request for patients with a diagnosis of **TRD**, has the patient had a trial of at least two oral antidepressants prior to initiating esketamine intranasal therapy?

Yes  No

Please provide the names of the most recent antidepressant therapies and dates of the trials:

Antidepressant and strength: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of use:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Antidepressant and strength: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of use:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Confirm patient observation by a healthcare practitioner for 2 hours during and after esketamine administration.

Yes  No

1. Is the patient on an oral antidepressant in conjunction with esketamine nasal spray?

Yes  No

Antidepressant and Strength: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Directions for Use:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Clinical Criteria – Continuation of Therapy

1. Utilizing the same baseline depression assessment tool, was there an improvement in the patient’s score while receiving esketamine treatment?

Yes  No

1. Before prescribing esketamine nasal spray was the New York State Prescription Monitoring Program reviewed?

Yes  No

1. Confirm patient observation by a healthcare practitioner for 2 hours during and after esketamine administration.

Yes  No

1. Is the patient on an antidepressant in conjunction with esketamine intranasal therapy?

Yes  No

Please provide the patient’s current antidepressant therapy and directions for use:

Antidepressant and Strength: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Directions for use:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Attestation

*I attest that this drug is medically necessary for this patient and that all of the information on this form is accurate to the best of my knowledge. I attest that documentation of the above diagnosis and medical necessity is available for review if requested by the New York State Medicaid Program.*

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| Prescriber Signature (Required) |  | Date (MM/DD/YYYY) |