commonwealth care alliance®

Date of Request

Esketamine Authorization Request

Clear Form

Request Information		
☐ **Expedited Request** *(by checking this box I certify that this request meets the below criteria for being Expedited and I will supply justification*)*		
Criteria for Expedited: Waiting for a decision within the standard time frame (up to 7 calendar days) could place the member's life, health, or ability to regain maximum function in serious jeopardy		
***Justification for Expedited:** (Attach pages if add'tl space is needed)		
Member Name:	**DOB:**	**Policy #**
Facility Name:	**Facility TIN**:	
MD Performing Treatment:	**Fax #**	☐ **Out of Network**
Provider Contact Name:	**Contact Phone**:	
Requested Procedure Code G2082 = G2083 =	**Primary Diagnosis** (Diagnosis code):	
Service Start Date:	**Service End Date**:	**Frequency**:

Please select **ONE:**

☐ Initial authorization

☐ Authorization renewal ***(skip to section on page 2 titled "For Authorization Renewals Only")***

Please select ONE**:**

☐ Major Depressive Disorder and acute suicidal ideation or behavior confirmed by a psychiatrist (urgent)

☐ Major Depressive Disorder with treatment resistant depression confirmed by psychiatrist ***OR***

☐ None of the above please specify:

Please select **YES or NO:**

Previous treatment with more than 2 antidepressants for at least 6 weeks each? ☐Yes ☐ No

Continued depression after treatment? ☐ Yes ☐ No

Pre-Esketamine treatment depression rating scale: GDS , PHQ-9 , BDI , HAM-D, MADRS , QIDS , or IDS-SR

Is the drug being prescribed Esketamine? ☐Yes ☐ No If no, indicate the drug to be prescribed:

Esketamine treatment to be used in combination with an oral antidepressant? ☐Yes ☐ No

Is treatment to be provided in a hospital setting by a provider? ☐Yes ☐ No

If no, describe setting

Is there a history of psychosis? ☐Yes ☐ No

If yes, does the prescriber believe the benefits of Esketamine outweigh the risks? ☐Yes ☐ No

Please select **ALL** that apply from the below indicators for Esketamine treatment:
☐ No history of aneurysmal vascular disease, arteriovenous malformation, or intracranial hemorrhage
☐ Monitoring planned after each administration
☐ Risks of sedation and dissociation after administration discussed with patient or caregiver
☐ Risk of abuse and misuse discussed with patient or caregiver
☐ Risk of increased suicidal thoughts and behavior discussed with patient or caregiver
☐ Not currently pregnant or breastfeeding and risks of pregnancy/breastfeeding discussed with patient or caregiver, or pregnancy testing not indicated
☐ Does not have a hypersensitivity to Esketamine or any excipients
☐ Does not have a current substance use disorder, unless in remission
☐ Has ***NOT*** had previous treatment that was determined not to reduce symptoms or be efficacious
OR
☐ Other clinical information

Complete the Following for Authorization Renewals Only

Please select **ALL** that apply from the below indicators for Continuation of Esketamine treatment:
☐ Drug being prescribed is Esketamine If no, indicate the drug to be prescribed:
☐ Administration and monitoring of Esketamine is to be provided in a hospital setting by a provider If no, describe setting
☐ Risk of abuse and misuse discussed with patient or caregiver
☐ Condition improved with treatment
Depression scale (initial & most recent): GDS ,PHQ-9 ,BDI , HAM-D , MADRS QIDS , or IDS-SR
☐ Manageable or no side effects
☐ Treatment used in combination with oral depressant
☐ Does not have a current substance use disorder, unless in remission
OR
Other clinical information:

Additional Comments: