[Insert Physician Letterhead]

[Date]

To whom it may concern,

| | |
|---|---|
| **Member name** | [Patient name] |
| **Date of birth** | [Patient date of birth] |
| **Member ID number** | [Member ID number] |
| **Member group/policy number** | [Member group/policy number] |
| **Appeal case ID number** | [Case ID number] |
| **Denial date** | [Date of appeal denial] |

I am writing on behalf of our shared member, [Patient Name] to appeal the denial of coverage for SPRAVATO® (esketamine) CIII Nasal Spray as a medically necessary treatment for [Patient Name] 's [Patient's diagnosis] .

SPRAVATO® CIII Nasal Spray is indicated for the treatment of:
• Treatment-resistant depression (TRD) in adults as monotherapy or in conjunction with an oral antidepressant.
• Depressive symptoms in adults with major depressive disorder (MDD) with acute suicidal ideation or behavior in conjunction with an oral antidepressant.

**According to your letter, coverage was denied due to** [reason as stated in the denial letter] . This appeal letter provides information about our shared member's medical history, diagnosis, and details regarding the medical necessity of the requested treatment with SPRAVATO®.

In support of my recommendation for SPRAVATO® treatment, I have provided an overview of the patient's relevant clinical history below. Please review my clinical rationale and attached documentation to assist with your coverage decision.

| | |
|---|---|
| **Primary Diagnosis** | [Indication] |
| **ICD-10-CM code(s)** | [ICD-10-CM codes] |
| **No. of prior therapies** | [No. of prior therapies] |
| **Description of prior therapies and treatment response** | [Description of prior therapy 1 and patient's treatment response] |
| **Relevant disease-related characteristics** | [Insert relevant disease-related characteristics] |
| **My professional opinion of the patient's likely prognosis or disease progression if they are not treated with SPRAVATO®** | [Insert your professional opinion of the patient's likely prognosis or disease progression if they are not treated with SPRAVATO®] |

ICD-10-CM=International Classification of Diseases, Tenth Revision, Clinical Modification.

**Rationale for Treatment**
[Summarize clinical rationale for treatment, including supporting evidence from:

- Prescribing information
- Treatment guidelines and/or recognized drug compendia
- Peer-reviewed literature]

In view of the above information and the enclosed documentation, I believe SPRAVATO® (esketamine) is medically necessary and appropriate and should be authorized for my patient.

Please note that our treatment center, [Treatment center] , is certified to administer SPRAVATO®, which is available through a restricted Risk Evaluation and Mitigation Strategy (REMS) program.

[Consider including documents that provide additional clinical information to support the recommendation for SPRAVATO® for this patient, such as FDA approval letter for the monotherapy indication (if submitting for monotherapy), the full Prescribing Information, peer-reviewed journal articles, or clinical guidelines.]

[Given the urgent nature of this request,] please provide a timely authorization. Contact my office at [Phone Number] if I can provide you with any additional information.

Sincerely,

[Insert Physician Name and Participating Provider Number]

Enclosures: [List any appropriate enclosures, such as:

- Full Prescribing Information for SPRAVATO®
- FDA approval letter for SPRAVATO® as monotherapy for TRD in adults
- Clinical notes and records
- Peer-reviewed journal articles
- Clinical guidelines]

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