

Member Name:  
Member Number:  
Group Number:

**REQUEST:** Authorization for treatment with SPRAVATO® (esketamine) Nasal Spray

**DIAGNOSIS:**

**DOSE AND FREQUENCY:**

**REQUEST TYPE:**  Standard  EXPEDITED

Dear \_\_\_\_\_ :

I am writing on behalf of our shared member, \_\_\_\_\_, to request that you approve coverage for SPRAVATO® (esketamine) as a medically necessary treatment for \_\_\_\_\_'s \_\_\_\_\_.

This letter provides information about our shared member's medical history, diagnosis, and details regarding the medical necessity of the requested treatment with SPRAVATO®.

**Summary of Patient's Diagnosis**

**Summary of Patient's History**

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History of previous pharmacological therapies	Reasons for discontinuation of previous therapies	Duration of previous therapies

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**Rationale for Treatment**

please provide a timely authorization. Contact my office at  
if I can provide you with any additional information.

Sincerely,

Enclosures:

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