[Insert Physician Letterhead]

[Insert Name of Medical Director]
[Insert Payer Name]
[Insert Address]
[Insert City, State ZIP]

RE: Member Name: [Insert Member Name]
Member Number: [Insert Member Number]
Group Number: [Insert Group Number]

REQUEST: Authorization for treatment with SPRAVATO® (esketamine) Nasal Spray CIII
DIAGNOSIS: [Insert Diagnosis] [Insert ICD]
DOSE AND FREQUENCY: [Insert Dose & Frequency]
REQUEST TYPE: ☐ Standard ☐ EXPEDITED

Dear [Insert name of Medical Director or name of individual responsible for prior authorization]:

I am writing on behalf of our shared member, [Patient Name] to request a formulary exception for SPRAVATO® (esketamine) for [Indication].

Summary of Patient's Diagnosis

[Insert patient's diagnosis, date of diagnosis, lab results and date, current condition]

Summary of Patient's History

[Insert:

- Previous therapies/procedures, including dose and duration, response to those interventions
- Description of patient's recent symptoms/condition
- Site of medical service—include appropriate site type: inpatient, hospital outpatient, outpatient clinic, private practice, or other
- Rationale for not using drugs that are on the plan's formulary
- Summary of your professional opinion of the patient's likely prognosis or disease progression without treatment with SPRAVATO®

Note: Exercise your medical judgment and discretion when providing a diagnosis and characterization of the patient's medical condition.]

Rationale for Treatment

[Insert summary statement for rationale for treatment such as: Considering the patient's history, condition, and the full Prescribing Information supporting uses of SPRAVATO®, I believe treatment with SPRAVATO® at this time is medically necessary, and should be a covered and reimbursed service.]

[You may consider including documents that provide additional clinical information to support the recommendation for SPRAVATO® for this patient, such as 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 [Insert Phone Number] if I can provide you with any additional information.

Sincerely,
[Insert Physician Name and Participating Provider Number]

Enclosures [Include full Prescribing Information and the additional support noted above]

© Johnson & Johnson and its affiliates 2025 07/25 cp-68046v5