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

**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.*

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