Clinical Criteria Worksheet:
Spravato® (esketamine) Nasal Spray

Enrollee Information

Enrollee Last Name: _____

Enrollee First Name: _____

Date of Birth (MM/DD/YYYY): ☐☐ / ☐☐ / ☐☐☐☐

Enrollee Medicaid ID (2 letters, 5 numbers, 1 letter): ☐☐☐☐☐☐☐☐☐

Address: _____

City, Town or Post Office: _____ **State:** _____ **ZIP Code:** _____

Prescriber Information

Prescriber Last Name: _____

Prescriber First Name: _____

National Provider Identifier (NPI) Number: _____

Preferred Contact (Telephone Number): _____

Clinical Criteria – Drug Information

Drug Administration:

Provide the date of drug administration (MM/DD/YYYY): ☐☐ / ☐☐ / ☐☐☐☐

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

Initiation of Therapy: ☐ Yes ☐ No

Date therapy initiated: _____

Continuation of Therapy: ☐ Yes ☐ No

Enrollee Last Name: **Enrollee First Name:**

_____ _____

Clinical Criteria – Diagnosis

1. ☐ Treatment-resistant depression (TRD)

   OR

   ☐ Depressive symptoms associated with acute suicidal ideation or behavior

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

2. Has the healthcare outpatient site and the patient been enrolled in the Spravato Risk Evaluation and Mitigation Strategy *(*REMS*)*?

   ☐ Yes ☐ No

3. Before prescribing esketamine nasal spray was the New York State Prescription Monitoring Program reviewed?

   ☐ Yes ☐ No

4. 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:_____

5. Confirm patient observation by a healthcare practitioner for 2 hours during and after esketamine administration.

   ☐ Yes ☐ No

Enrollee Last Name: **Enrollee First Name:**

_____ _____

6. 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

2. Before prescribing esketamine nasal spray was the New York State Prescription Monitoring Program reviewed?

   ☐ Yes ☐ No

3. Confirm patient observation by a healthcare practitioner for 2 hours during and after esketamine administration.

   ☐ Yes ☐ No

4. 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)**