Esketamine Treatment Request

DATE	INSURED'S EMPLOYER		
PATIENT LAST NAME	FIRST NAME	DATE OF BIRTH	AGE

PROVIDER INFORMATION:

PSYCHIATRIST	PHONE	FAX	NAME OF PRACTICE
PRIMARY CONTACT	PHONE	FAX	REFERRING PHYSICIAN

DSM-5 DIAGNOSIS:

1. _____ 3. _____
2. _____ 4. _____

CURRENT RISK?

Is there dangerousness due to suicidal ideation or behavior?

Yes ☐ No ☐

CURRENT PSYCHOTROPIC MEDICATIONS? Yes ☐ No ☐

If Yes, list all including dose and start date:

1. _____ 3. _____
2. _____ 4. _____

TREATMENT RESISTANT DEPRESSION? Yes ☐ No ☐

If Yes, check all medication trials that apply:

1. Antidepressant ☐
2. Antidepressant, Different Class ☐
3. Antidepressant with Augmentation ☐
4. Other: _____ ☐

For **EACH** medication prescribed at the **maximum recommended dose,** the following **must be** provided to document Treatment Resistant Depression:

	Medication Name:	Prescribed Dose:	Number of Weeks Maximum Dose Taken:
1.			
2.			
3.			
4.			
5.			

CURRENT ESKETAMINE TREATMENT AUTHORIZATION REQUEST:

CPT CODES REQUESTED:	FREQUENCY:

_____ _____

Physician Signature **Date**