PRIOR AUTHORIZATION PROGRAM REIMBURSEMENT REQUEST FORM
For anti-depressant therapy: SPRAVATO (esketamine)

Please fax form to: 1-866-840-1509

Please note that the patient **AND** physician must complete this form. **All fields are mandatory and must be completed. Incomplete forms may result in your application being declined.** Please retain a copy of this form for your records.

Instructions:

1. **PLEASE PRINT CLEARLY AND COMPLETE ALL SECTIONS.**
2. The patient/plan member must complete section A.
3. Your physician must complete section B. The cost, if any, of completing this form is at the expense of the patient/plan member.
4. Please return the form to your insurance company via Pharmacy Services at TELUS Health (a service provider of your insurance company) by fax to **1-866-840-1509**.
5. If you have any questions on the application of this program or the decision on reimbursement, or to inquire on the status of your Reimbursement Request Form, please contact your insurer.

A. Information to be Completed by the Patient

Member's or Recipient's Name	Drug Card Number __ __ - __ __ __ __ __ __ - __ __ __ __ __ __ __ __ __ __ - __ __	
Patient's Name	Patient's Date of Birth (DD/MMM/YYYY) __ __ / __ __ __ / __ __ __ __	Relationship to Member ❑ Member ❑ Spouse ❑ Dependent

Please allow two business days for a response once all information is received and complete.
Notification of the results of this request will occur Monday to Friday between 9 a.m. and 4 p.m. Eastern Time.

Please provide contact information and indicate **ONE** method of preferred contact for notification of the results:

❑ E-mail:	❑ Call me (and leave a message if I'm not there):	❑ Fax me:
❑ Contact my pharmacy Pharmacy Name:		Pharmacy Phone Number:

I certify that the information provided by me is true, correct and complete to the best of my knowledge. I authorize my insurance company, TELUS Health (a service provider of my insurance company), their authorized representatives, agents and service providers to use and exchange this information needed for underwriting, administration and paying claims with any person or organization who has relevant information pertaining to this claim including health professionals, institutions and investigative agencies in the event of an audit. I authorize my insurance company and/or TELUS Health (a service provider of my insurance company) to contact any licensed physician, institution, pharmacy or person who has any records or knowledge of me or my health with respect to this submitted claim.

SIGNATURE OF PATIENT/PARENT/LEGAL GUARDIAN _____

Date: (DD/MMM/YYYY): __ __ / __ __ __ / __ __ __ __

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B. Information to be Completed by Prescribing Physician

Drug Name	Strength	Dose
Spravato (esketamine)		

Spravato (esketamine) **will be eligible for reimbursement only if the patient satisfies the conditions listed below and if the patient does not qualify for coverage under any other drug plan or government mandated program. If the patient is covered under another drug plan or government mandated program, the prior authorization program, as part of your drug benefits, may cover the portion not paid for by the primary plan. If "None of the above criteria" is indicated, the patient will not be eligible for reimbursement. For Quebec plan members, please refer to the RAMQ exception drug criteria, if applicable.**

Eligibility Criteria

Please indicate if the patient satisfies one of the following criteria:

Short-term treatment of major depressive disorder requiring urgent psychiatric care (approval period of 4 weeks)

- ❑ For the rapid reduction of depressive symptoms in adult patients with a moderate to severe episode of major depressive disorder, AND
- ❑ The patient:
  - Is ≥18 years of age; AND
  - Meets the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) diagnostic criteria for MDD without psychotic features; AND
  - Requires urgent psychiatric care, according to the clinical judgement of the prescriber; AND
  - Has a Montgomery-Åsberg Depression Rating Scale (MADRS) total score of greater than (>) 28; AND
  - Is currently receiving treatment with any oral antidepressant; AND
  - The treatment period will not exceed four weeks; AND
  - Must be enrolled in the JANSSEN JOURNEY™ Program
- The prescriber is experienced and proficient in the management of major depressive disorder and enrolled in the JANSSEN JOURNEY™ Program

Major depressive disorder in adults who have not responded to at least two prior therapies (approval period of 3 months):

- ❑ For the treatment of moderate to severe depressive episodes for patients with major depressive disorder (MDD)
- ❑ The patient:
  - Is ≥18 years of age; AND
  - Meets the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) diagnostic criteria for MDD
  - Has major depressive episodes that meet the depression symptom severity Montgomery–Åsberg Depression Rating Scale (MADRS) score ≥ 28; AND
  - Has not responded adequately to at least two separate courses of treatment with different antidepressants from two different classes, each of adequate dose and duration for at least 4 weeks unless clinically significant adverse effects are experienced; AND
  - Has tried and failed for at least 4 weeks both of the following augmentation treatments:
    - Two antidepressants used together; AND
    - An antidepressant plus a non-antidepressant medication (e.g. atypical antipsychotic, lithium, thyroid hormone)
  - Is currently on an oral antidepressant for at least two weeks at or above the minimum therapeutic dose; AND
  - Will be treated with SPRAVATO in combination with a selective serotonin reuptake inhibitor (SSRI) or serotonin-norepinephrine reuptake inhibitor (SNRI); AND
  - Must be enrolled in the JANSSEN JOURNEY™ Program

- ❑ The prescriber is experienced and proficient in the management of major depressive disorder and enrolled in the JANSSEN JOURNEY™ Program

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Eligibility Criteria
Renewal Criteria: Major depressive disorder in adults who have not responded to at least two prior therapies (approval period of 1 year): ❑ Demonstrated remission or clinical response (e.g., score reduction from baseline) in at least one of the following assessments: ❑ Patient Health Questionnaire (PHQ-9); remission defined as a score of < 5; OR ❑ Quick Inventory of Depressive Symptomatology (QIDS-C16; remission defined as a score of ≤ 5); OR ❑ Hamilton Rating Scale for Depression (HAMD17; remission defined as a score of ≤7); OR ❑ Montgomery-Asberg Depression Rating Scale (MADRS; remission defined as a score of ≤ 12) OR ❑ None of the above applies Relevant additional information _____

Physician Information				
Physician's Name	License Number	Telephone Number	Fax Number	
Address		City	Province	Postal Code
Physician's Signature			Date: (DD/MMM/YYYY) __ __ / __ __ __ / __ __ __ __	