[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]:

I am writing to request a **formulary exception** for the above-mentioned patient to receive treatment with SPRAVATO® for [insert indication], dosed concomitant with [insert oral antidepressant]. My request is supported by the following:

**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]