Beneficiary Full Name: _____ Sponsor's SSN: _____-_____-_____

Date of Birth: _____ Beneficiary State of Residence: _____

Dear Provider,

Please complete the letter of attestation below and return as indicated on the additional information request letter or attach it to your online request.

TRICARE Policy Manual, Chapter 7, Section 3 authorizes coverage of Spravato®, also known as esketamine, nasal spray for the treatment of treatment-resistant depression.

In order for Spravato® to be covered, the care must be prior authorized and the provider must attest that the following statements are true:

- ☐ The beneficiary is 18 years or older,
- ☐ has failed to respond to a less intensive form of treatment,
- ☐ has failed two medication trials,
- ☐ has treatment-resistant depression (TRD),
- ☐ diagnosed with major depressive disorder with acute suicidal ideation or behavior,
- ☐ currently on an antidepressant and
- ☐ is enrolled in the U.S. Food and Drug Administration's Spravato™ Risk Evaluation and Mitigation Strategy (REMS) program.

I attest the information provided is true and accurate to the best of my knowledge. I understand Health Net Federal Services, LLC or designee may perform a routine audit and request the medical documentation to verify the accuracy of the information reported on this form.

Additional information:

_____

_____

Physician's printed name and title:_____

TIN: _____ Signature: _____ Date: _____

Authorizations and Referrals • PO Box 9108 • Virginia Beach, VA 23450-9108