

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: _____

This document may contain information covered under the Privacy Act (5 USC §552a) and/or the Health Insurance Portability and Accountability Act (P.L.104-191) and its various implementing regulations and must be protected in accordance with those provisions. If you have received this correspondence in error, please notify 1-844-866-WEST (9378) at once and destroy the documents and any copies you have made.

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

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