# Drug Prior Authorization Form
# Spravato (Esketamine)

The purpose of this form is to obtain information required to assess your drug claim.

**IMPORTANT:** Please answer all questions. Your claim assessment will be delayed if this form is incomplete or contains errors.

**Any costs incurred for the completion of this form are the responsibility of the plan member/patient.**

Canada Life recognizes and respects the importance of privacy. Personal information collected is used for the purposes of assessing eligibility for this drug and for administering the group benefits plan. For a copy of our Privacy Guidelines, or if you have questions about Canada Life's personal information policies and practices (including with respect to service providers), refer to www.canadalife.com or write to Canada Life's Chief Compliance Officer.

I authorize Canada Life, any healthcare provider, my plan administrator, any insurance or reinsurance company, administrators of government benefits or patient support programs or other benefits programs, other organizations, or service providers working with Canada Life or any of the above, located inside or outside Canada, to exchange personal information when relevant and necessary for these purposes. I understand that personal information may be subject to disclosure to those authorized under applicable law within or outside Canada.

I acknowledge that the personal information is needed to assess eligibility for this drug and to administer the group benefits plan. I acknowledge that providing consent will help Canada Life to assess my claim and that refusing to consent may result in delay or denial of my claim. Canada Life reserves the right to audit the information provided on this form at any time and this consent extends to any audit of my claim. This consent may be revoked by me at any time by sending written instruction to that effect.

I also consent to the use of my personal information for Canada Life and its affiliates' internal data management and analytics purposes.

If the patient is a person other than myself, I confirm that the patient has given their consent to provide their personal information and for Canada Life to use and disclose it as set out above.

I certify that the information given below is true, correct, and complete to the best of my knowledge. Failure to provide true, correct and complete information on this form could result in revocation of any approval decision, a requirement to repay paid claims or other appropriate action.

Plan Member's signature: _____ Date: _____

## Form Completion Instructions:

1. **Complete "Patient Information" sections.**
2. **Have the prescribing physician complete the "Physician Information" sections.**
3. **Send all pages of the completed form to us by mail, fax or email as noted below.**

**Note:** As email is not a secure medium, any person with concerns about their prior authorization form/medical information being intercepted by an unauthorized party is encouraged to submit their form by other means.

**Mail to:** **The Canada Life Assurance Company**
**Drug Claims Management**
**PO Box 6000**
**Winnipeg MB R3C 3A5**

**Fax to:** **The Canada Life Assurance Company**
**Fax 1-204-946-7664**
**Attention: Drug Claims Management**

**Email to:** **cldrug.services@canadalife.com**
**Attention: Drug Claims Management**

For additional information regarding Prior Authorization and Health Case Management, please visit our Canada Life website at www.canadalife.com or contact Group Customer Contact Services at 1-800-957-9777. Deaf or hard of hearing and require access to a telecommunications relay service? Please contact us at 711 for TTY to Voice or 1-800-855-0511 for Voice to TTY.

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# Patient Information
# Spravato (Esketamine)

## Plan Member Information – Complete all sections of this page (please print)

| Plan Member: | Patient Name: | |
|---|---|---|
| Plan Name: | Plan Number: | Plan Member ID Number: |
| Patient Date of Birth (DD/MM/YYYY): | Address (number, street, city, province, postal code): | |

Please indicate preferred contact number and if there are any times when telephone contact with you about your claim would be most convenient.

May we contact you by email? (Note that some correspondence may still need to be sent by regular mail).

☐ Yes ☐ No If yes, please provide email address: _____

## Tell us if you have been on this drug before

Is the patient currently on, or previously been on this drug? ☐ Yes ☐ No

If Yes, a) indicate start date (DD/MM/YYYY): _____

b) coverage provided by: _____

(if coverage is not provided by Canada Life please provide pharmacy print-out showing purchase of this drug)

## Tell us if you have coverage with any other benefits plan

Does the patient have drug coverage under any other group benefits plan? ☐ Yes ☐ No

If Yes, name of other Insurance Company: _____

If other plan is with Canada Life, tell us the plan and ID number: _____

Name of plan member: _____

Relationship to patient: _____

**Provide details and attach documentation of acceptance or decline:**

_____

_____

## Tell us about any Provincial or other coverage you may have

Does the patient have coverage under a provincial program or from any other source? ☐ Yes ☐ No

If Yes, name of program or other source: _____

Provide details and attach documentation of acceptance or decline: _____

Is the patient currently receiving disability benefits for the condition for which this drug has been prescribed? ☐ Yes ☐ No

## Tell us about any Patient Support Program you might be enrolled in

Has the patient enrolled in the patient support program for this drug? ☐ Yes ☐ No

If Yes, please provide the following information:

1. Patient support program patient ID Number: _____
2. Patient support program contact person name and phone number:

   Contact Name: _____ Phone Number: _____



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# Physician Information
# Spravato (Esketamine)

**Note to Physician: In order to assess a patient's claim for this drug, we require detailed information on the patient's prescription drug history as requested below.**

**Attach extra information if necessary. *GENETIC TEST RESULTS ARE NOT REQUIRED***

## Physician's Information (please print)

Name of prescribing physician:

Specialty:

Address (number, street, city, province, postal code):

| Telephone Number (including area code): | Fax Number (including area code): |
|---|---|
| | |

1. Health Canada indication, prescribed dosage and regimen:

☐ Major Depressive Disorder

Week 1-4 dose: _____ mg administered weekly

Week 5-8 dose: _____ mg administered weekly

Week 9 and onward: _____ mg administered every _____ week(s)

☐ Major Depressive Disorder requiring urgent psychiatric care

☐ 84mg twice per week for 4 weeks

☐ Other (please specify): _____

Provide rationale: _____

Complete questions 1 – 4 and Physician's Information

☐ Other (approved by Health Canada): _____

Complete questions 1 – 4 and Other Condition (Health Canada approved)

☐ Other (prescribed use is not approved by Health Canada): _____

Complete questions 1 – 4 and Off-label use

2. Where will treatment be administered? ☐ Home ☐ Physician's Office ☐ Private clinic ☐ Hospital in-patient ☐ Hospital out-patient

3. Please provide medical rationale why this drug has been prescribed instead of an alternate drug in the same therapeutic class:

_____

_____

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# Physician Information
# Spravato (Esketamine)

## Physician's Information *(continued)* (please print)

4. Drug and Treatment History - must be completed for every request.

| Drug(s) and Treatment(s) past and present | Dosing Regimen | Start Date (DD/MM/YYYY) | End Date (DD/MM/YYYY) | Clinical Results/Outcome |
|---|---|---|---|---|
| | | | | ☐ Failure ☐ Intolerance ☐ Other<br>Clinical details: |
| | | | | ☐ Failure ☐ Intolerance ☐ Other<br>Clinical details: |
| | | | | ☐ Failure ☐ Intolerance ☐ Other<br>Clinical details: |
| | | | | ☐ Failure ☐ Intolerance ☐ Other<br>Clinical details: |

## Major Depressive Disorder (MDD)

Is the prescriber enrolled in the JANSSEN JOURNEY™ Program? ☐ Yes ☐ No

Does the patient have a diagnosis of MDD without psychotic features as per DSM-5-TR diagnostic criteria and confirmed by Mini International Neuropsychiatric Interview? ☐ Yes ☐ No

Date of initial diagnosis (MM/YYYY): _____

**Current depressive episode**

Provide date of onset of current depressive episode, if different from date of initial diagnosis (MM/YYYY): _____

Current ☐ MADRS ☐ PHQ-9 ☐ HAM-D score: _____ Date determined (DD/MM/YYYY): _____

For the current depressive episode (select all that apply):

- ☐ Patient is unable to achieve clinical meaningful improvement with two or more pharmacologically different oral antidepressants at the maximally tolerated effective doses for at least 8 weeks
- ☐ Patient has tried and failed for at least 4 weeks of two concurrent oral antidepressants **OR** one antidepressant plus an adjunctive therapy (e.g. antipsychotic)
- ☐ Other. Please specify: _____

Spravato will be administered (select all that apply):

- ☐ in combination with an oral antidepressant (either SSRI or SNRI)
- ☐ under the direct supervision of a health care provider

Complete Drug and Treatment history chart above for **current** depressive episode. If coverage for these drugs was not provided by Canada Life, please submit a pharmacy printout for the last 12 months.

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# Physician Information
# Spravato (Esketamine)

## Physician's Information *(continued)* (please print)

**Renewal Request**

Current ☐ MADRS ☐ PHQ-9 ☐ HAM-D score: _____ Date determined (DD/MM/YYYY): _____

**Note:** Must use the same score provided upon initial request

Will Spravato continue to be administered in combination with an oral antidepressant (SSRI or SNRI)? ☐ Yes ☐ No

## Major Depressive Disorder requiring urgent psychiatric care

Is the prescriber enrolled in the JANSSEN JOURNEY™ Program? ☐ Yes ☐ No

Will Spravato be used for the treatment of moderate to severe episode of major depressive disorder that requires urgent psychiatric care according to clinical judgement? ☐ Yes ☐ No

Does patient have active suicidal ideation? ☐ Yes ☐ No

Current ☐ MADRS ☐ PHQ-9 ☐ HAM- D score: _____ Date determined (DD/MM/YYYY): _____

Will Spravato be used in combination with newly initiated or optimized oral antidepressant therapy? ☐ Yes ☐ No

**Please ensure Drug and Treatment History chart on the previous is complete**

## Other condition (Health Canada approved)

Please provide any relevant information related to the disease and attach supporting documentation.

_____

_____

## Off-label use

**Questions 1 – 4 must be completed.**

Date of initial diagnosis (DD/MM/YYYY): _____

Is there clinical evidence supporting the off-label use of this drug? ☐ Yes ☐ No

Provide clinical literature / studies to support the request for off-label use, such as:

- At least two Phase II or two Phase III clinical trials showing consistent results of efficacy; and
- Published recommendations in evidence-based guidelines supporting its use.

Provide medical rationale why this drug has been prescribed off-label instead of an alternative drug with an approved indication for this condition.

_____

_____

Provide any pertinent medical history or information to support this off-label request.

_____

_____

If this is a renewal request, provide documentation showing efficacy since previous request.

_____

# Physician Information
# Spravato (Esketamine)

**Note for Physician: To be eligible for reimbursement, Canada Life may require your patient to purchase a drug requiring prior authorization from a pharmacy designated by Canada Life. If applicable, a health case manager will contact you with further information.**

**I certify that the information provided is true, correct, and complete.**

Physician's Signature: _____ Date: _____

License Number: _____

It is important to provide the requested information in detail to help avoid delay in assessing claims for the above drug. This form may be subject to audit. The completed form can be returned to Canada Life by mail, fax, or email.

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