Washington State Department of Labor & Industries

Esketamine Nasal Spray for Depression with Acute Suicidality

Office of the Medical Director
PO Box 44231
Olympia WA 98504-4321

Please fax complete form along with any supportive medical documentation to 360-902-6315. Write the claim number on every page.

Worker's Name	Claim Number

Section 1			
Criteria for one-time 30-day authorization (all of the following must be met):			
1.	Is major depressive disorder accepted or is treatment currently authorized?	☐ Yes	☐ No
2.	Is the worker currently experiencing acute suicidality?	☐ Yes	☐ No
3.	Will the esketamine nasal spray be in used conjunction with an oral antidepressant? If "Yes", which antidepressant and dose?	☐ Yes	☐ No
4.	Is the provider certified in the esketamine nasal spray REMS program?	☐ Yes	☐ No
5.	Has the provider verified that the worker has no current or history of aneurysmal vascular disease, arteriovenous malformation, intracerebral hemorrhage, psychosis, or substance use disorder, and any other cautions have been appropriately addressed?	☐ Yes	☐ No

Section 2	
Prescriber Name	Prescriber Phone Number
Signature	Date

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