1 Portland Street, P.O. Box 160
Saint John, N.B. E2L 3X9
Toll-free 1 800 999-9775
Fax 506 632-2819
Web worksafenb.ca

1, rue Portland, case postale 160
Saint John NB E2L 3X9
Sans frais 1 800 999-9775
Télécopieur 506 632-2819
Web travailsecuritairenb.ca

Ketamine/Esketamine Review

Important Information

Please work through the following pages with your patient or the patient's chart as necessary. Fax completed documents to 1 888 629-4722. Keep the original in your chart / file.

I, _____ request full reimbursement for completing the Ketamine/Esketamine Review booklet for my patient, _____.

Physician name: _____

Signature: _____

Date: _____

Payee Code: _____

FOR QUESTIONS on completing this form please contact WorkSafeNB toll-free at 1 800 999-9775.

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Ketamine/Esketamine Approval, Documentation and Treatment Review Booklet

The Ketamine/Esketamine workbook must be completed by the treatment provider. It allows for systematic documentation and review of the ketamine/esketamine treatment process. The treatment provider is responsible to provide the required information in the Pre-Approval Request Section and submit prior to treatment authorization. The treatment provider is also responsible to complete the requested information in the Monitoring and Reporting Section and the Long-Term Reporting Section of the form as indicated.

Pre-Approval Request Section
- Upon receipt of the information in the Pre-Approval Request Section, WorkSafeNB will complete an internal review and provide a reference number if the treatment is approved.
- Please see page 3 of the review booklet.

Monitoring and Reporting Section
- The treatment provider completes this section of the form after **each treatment session**, documenting the patient's status.
- Please see page 4 of the review booklet.

Long-Term Reporting Section
- The treatment provider submits ongoing reports in this section of the form including Patient Health Questionnaire (PHQ-9), for long-term monitoring at baseline, 4-6 weeks, 3 months, 6 months and 9 months.
- Please see page 6 of the review booklet.

The physical and psychological monitoring and safety during each session are tracked in real-time, while ongoing monitoring and quarterly reviews ensure that the treatment is continuously evaluated for safety and efficacy.

Health care professionals must complete all sections of the workbook in full to ensure WorkSafeNB's standard for excellence in client care and patient safety.

Pre-Approval Request Section

This form will be completed by the **treatment provider** to request pre-approval for ketamine/esketamine treatment.

Patient name: _____

Date of birth: _____

Address: _____

Phone number: _____

Claim number: _____

Current risk of suicide: ☐ None ☐ Low ☐ Medium ☐ High

Please provide baseline score of the Patient Health Questionnaire (PHQ-9): _____

Please provide a list of prescriptions of first line psychotropics trialed in advance of treatment (attach or enter brief notes):

_____

_____

_____

Detailed treatment plan and justification:

_____

_____

_____

Expected outcomes and milestones:

_____

_____

_____

CHECKLIST

☐ Patient has an accepted compensable injury AND meets DSM-5-TR criteria for Major Depressive Disorder

☐ No exclusion criteria present (e.g., no psychotic disorder, bipolar disorder, OCD, Cluster B personality, active substance use disorder without a safety statement)

☐ Statement of safety submitted if applicable

☐ Treatment and monitoring plan provided and aligns with WorkSafeNB and billing standards

Provider signature: _____

Date: _____

Monitoring and Reporting Section

This section will be used by the **treatment provider** to report on each session after the pre-approval process.

SESSION CHECKLIST (treating nurse or physician)

☐ Date and time of treatment session: _____

☐ Cardiorespiratory monitoring log:

Pre-session vital signs recorded ☐ HR ☐ BP ☐ 02 stats ☐ RR

Continuous monitoring recorded ☐ HR ☐ BP ☐ 02 stats ☐ RR

Post-session vital signs recorded ☐ HR ☐ BP ☐ 02 stats ☐ RR

☐ Attending healthcare professionals:

Airway management expert name and credentials: _____

Signature confirming attendance and patient stability: _____

PSYCHOLOGICAL MONITORING LOG (treating nurse or physician)

Pre-session psychological state (attach or enter brief notes):

_____

_____

_____

Immediate post-session psychological state based on up to two hours of monitoring (note any observed transient dissociative symptoms—attach or enter brief notes):

_____

_____

_____

Adverse effects noted during session:

_____

_____

_____

Patient's feedback:

_____

_____

_____

Patient Information:

Patient name: _____

Date of session: _____ Session number: _____

Physical and Psychological Monitoring:

☐ Physical condition stable during the session

☐ No adverse reactions or side effects

☐ Psychological condition stable

Evaluation of potential side effects:

_____

_____

_____

Additional notes:

_____

_____

_____

Provider signature:_____ Date: _____

Long-Term Reporting Section

Patient name: _____ Date of report: _____

Time since start of treatment: _____ months

☐ Psychological assessment record typewritten (treating doctor) (attach the PHQ-9 test): www.worksafenb.ca/media/63128/phq-9-test.pdf

Monitoring of impact: PHQ-9 scores since beginning treatment:

	Baseline	4-6 weeks	3 months	6 months	9 months
Date					
PHQ-9 Score					

Additional psychological scores (if applicable):

_____

_____

_____

Benefits seen and documented in assessments:

_____

_____

_____

Changes in treatment plan:

_____

_____

_____

Provider comments on progress:

_____

_____

_____

Provider signature:_____ Date: _____