Phone: 845-789-5648
Fax: 845-789-4104
NCPDP 5851476
NPI: 1457297335

SPRAVATO REFERRAL FORM

Patient Name _____ Today's Date_____ ☐ *NEW* Patient ☐ *CURRENT Patient*
DOB _____ Height _____ Weight _____ ☐ Male ☐ Female Preferred Language _____
Best Phone _____ Email _____
Street Address _____ Apt#_____ City _____ State _____ Zip _____
Ship to Patient at: ☐ Home ☐ Physician Office ☐ Work Address _____
Allergies _____
Current Medications including OTC's (*please fax a complete list*) _____

Please Fax Insurance Card(s) both sides
Insured's Name _____
Relation to Patient _____
Primary Insurance _____
ID# _____ Group # _____
Secondary Insurance _____
ID# _____ Group # _____

Ordering Prescriber _____
Office Contact _____
Street Address _____ Suite #_____
City _____ State _____ Zip _____
Tel _____ Fax _____
Email _____
License# _____
NPI# _____
DEA# _____

Credentials: ☐ Physician ☐ Physician Assistant ☐ Nurse ☐ Pharmacist ☐ Other _____
Specialty: ☐ Psychiatry ☐ Internal Medicine ☐ Family Practice ☐ Other _____

ICD-10 Code
☐ **F33.1** Major Depressive Disorder (MDD), recurrent, moderate
☐ **F33.9** MDD, recurrent, unspecified
☐ **F33.40** MDD, recurrent, in remission, unspecified
☐ **F33.41** MDD, recurrent, in partial remission
☐ **F33.42** MDD, recurrent, in full remission
☐ **Other** Code: _____ Diagnosis: _____

Approximate date of diagnosis (mm/dd/yyyy) _____ / _____ / _____

☐ The patient with Major Depressive Disorder (MDD) and in the current depressive episode, has not responded adequately to at least two different antidepressants of adequate dose and duration.

Treatment History: Select any therapies previously prescribed within the current depressive episode:
☐ Celexa (citalopram)
☐ Pexeva (paroxetine mesylate)
☐ Cymbalta (duloxetine)
☐ Prozac (fluoxetine)
☐ Lexapro (escitalopram)
☐ Fetzima (levomilnacipran)
☐ Effexor (venlafaxine)
☐ Paxil (paroxetine)
☐ Effexor XR (venlafaxine XR)
☐ Pristiq (desvenlafaxine)
☐ Khedezla (desvenlafaxine succinate)
☐ Zoloft (sertraline)
☐ Other _____

☐ The patient with Major Depressive Disorder (MDD) and in the current depressive episode, has not responded adequately to at least two different antidepressants of adequate dose and duration.

☐ Yes ☐ No Has the patient previously been treated with ketamine for a treatment-resistant depression, pain syndromes or any other condition?
If YES, list all pre-existing conditions treated with ketamine: _____

List all pre-existing psychiatric and/or medical conditions: _____

List any concomitant medications (e.g., oral antidepressants, adjunctive depression medications, sedative hypnotics, MAOIs, etc):

PLEASE SEE PAGE 2 FOR PRESCRITION

My signature certifies that the person named on this form is my patient and that the information provided on this enrollment form is complete and accurate to the best of my knowledge. I certify this therapy to be medically necessary.
My signature authorizes The Pharmacy and its representatives to act as the agent to execute the insurance prior authorization process, assist the above named patient enroll into patient support programs, and appeal on behalf of prescriber and patient in the event of a prior authorization denial.

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.
PLEASE NOTE: The Pharmacy can only accept original prescription drug orders from patients, faxed prescriptions can be accepted only from the prescribing practitioners.

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Patient Name _____ Today's Date_____

PRESCRIPTION

Qualifications

☐ Patient must meet the DSM-5 diagnostic criteria for single-episode major depressive disorder (MDD) with the duration of greater than or equal to 2 years; OR recurrent MDD without psychotic features

☐ Patient must have had an inadequate response to at least 2 oral antidepressant treatments taken at adequate dosage and for adequate duration which is defined as the following:
The trial was at least 6 weeks at generally accepted doses; AND patient was ≥80% adherent during the trial

☐ Patient must have depression symptom severity of at least 28 on the MADRS rating scale

☐ **SPRAVATO®** (esketamine) **nasal spray** ☐ 56 mg ☐ 84 mg

***This is a controlled substance.** Please fax a copy of this form along with your electronic prescription.*

NCPDP #: _____

☐ ***Treatment-Resistant Depression***

- Induction Phase Weeks 1 to 4: Administer twice per week Day 1 starting dose: 56 mg; Subsequent doses: 56 mg or 84 mg
- Maintenance Phase Weeks 5 to 8: Administer once weekly 56 mg or 84 mg
- Week 9 and after: Administer every 2 weeks or once weekly* 56 mg or 84 mg

* Dosing frequency should be individualized to the least frequent dosing to maintain remission/response.

☐ ***Major Depressive Disorder with Acute Suicidal Ideation or Behavior*** Administer SPRAVATO in conjunction with an oral antidepressant.

The recommended dosage of SPRAVATO for this treatment is 84 mg twice per week for 4 weeks.

Dosage may be reduced to 56 mg twice per week based on tolerability. After 4 weeks of treatment, evidence of therapeutic benefit should be evaluated to determine need for continued treatment.
The use of SPRAVATO, in conjunction with an oral antidepressant, beyond 4 weeks has not been systematically evaluated in the treatment of depressive symptoms in patients with MDD with acute suicidal ideation or behavior.

Administration

☐ **Spravato** is only to be administered under direct supervision of a healthcare professional with adequate patient monitoring facilities

☐ Provider, patient, and facility must be enrolled in the **Spravato (esketamine) REMS program**

Will your office be administering Spravato?

☐ **Yes, all doses at our practice:**

☐ **No, Please visit provider indicated:**

Practice _____

Address _____

Phone: _____ Fax: _____

SPRAVATO® REMS (RISK EVALUATION AND MITIGATION STRATEGY)

What is the purpose of the REMS? The goal of the REMS is to mitigate the risks of serious adverse outcomes resulting from sedation and dissociation caused by SPRAVATO administration, and abuse and misuse of SPRAVATO by:

- Ensuring that SPRAVATO is only dispensed and administered to patients in a medically supervised healthcare setting that monitors these patients
- Ensuring pharmacies and healthcare settings that dispense SPRAVATO are certified
- Ensuring that each patient is informed about the serious adverse outcomes resulting from sedation and dissociation and need for monitoring
- Enrolling all patients who receive treatment in an outpatient healthcare setting in a registry to further characterize the risks and support safe use

☐ **ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM**

Prescriber's Signature (signature required. NO STAMPS)_____ **Date** _____

My signature certifies that the person named on this form is my patient and that the information provided on this enrollment form is complete and accurate to the best of my knowledge. I certify this therapy to be medically necessary.
My signature authorizes The Pharmacy and its representatives to act as the agent to execute the insurance prior authorization process, assist the above named patient enroll into patient support programs, and appeal on behalf of prescriber and patient in the event of a prior authorization denial.

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