Spravato® Enrollment Form

Date:_______________

Patient Data

Patient Name: ______________________________ Birthdate: ____________
SSN #: XXX-XX-______________________________
Address: ______________________________
Home Phone: __________________ Cell Phone: __________________
Alternate Caregiver Name: ______________________________

Sex: ❑ Male ❑ Female Height: _____ Weight: ________ lbs kg
Known Allergies: ______________________________
City: ______________ State: ____________ Zip: ____________
Primary Language: ______________________________
Phone of Caregiver: ______________________________

Ins. Data

Primary Insurance: ______________________________
Policy: ______________________________ Group#: ____________

Secondary Insurance: ______________________________
Policy: ______________________________ Group#: ____________

Diagnosis Information

- ❑ F32.0 .... Major depressive disorder, single episode, mild
- ❑ F32.1 .... Major depressive disorder, single episode, moderate
- ❑ F32.2 .... Major depressive disorder, single episode, severe without psychotic features
- ❑ F32.4 .... Major depressive disorder, single episode, in partial remission
- ❑ F32.5 .... Major depressive disorder, single episode, in full remission
- ❑ F32.9 .... Major depressive disorder, single episode, unspecified
- ❑ F33.0 .... Major depressive disorder, recurrent, mild
- ❑ F33.1 .... Major depressive disorder, recurrent, moderate
- ❑ F33.2 .... Major depressive disorder, recurrent, severe without psychotic features
- ❑ F33.40 .... Major depressive disorder, recurrent, in remission, unspecified
- ❑ F33.41 .... Major depressive disorder, recurrent, in partial remission
- ❑ F33.42 .... Major depressive disorder, recurrent, in full remission
- ❑ F33.9 .... Major depressive disorder, recurrent, unspecified
- ❑ Other .... ______________________________

REMS

❑ Prescribing Facility's REMS ID# ____________________

❑ Patient's REMS ID# ____________________

Clinical

Please attach clinical notes and supportive documentation to expedite the prior authorization.

Has the patient been diagnosed with recurrent major depressive disorder? ❑ Yes ❑ No

Has the patient been treated for this disorder in the past? ❑ Yes ❑ No

If yes, past medications failed (length of therapy): ______________________________

Prescription

Medication	Directions			Quantity	Refills
❑ Spravato®	Induction Phase:	Weeks 1 - 4 Administer intranasally twice weekly	Day #1 Starting dose 56 mg Subsequent Dose: ❑ 56 mg ❑ 84 mg	#1 Box # ______ Box(es)	
	Maintenance Phase:	Weeks 5 - 8 Administer intranasally once weekly	❑ 56 mg ❑ 84 mg	# ______ Box(es)	
		Weeks 9 and after Administer intranasally every _____week(s)	❑ 56 mg ❑ 84 mg	# ______ Box(es)	

Is patient new to this therapy? ❑ YES ❑ NO

Prescriber Data

Prescriber Name: ______________________________
Practice Name: ______________________________
Address: ______________________________
City: ______________ State: ____________ Zip: ____________

DEA#: ____________________ NPI: ____________________
Contact: ______________ Preferred Method: ❑ Phone ❑ Fax ❑ Email
Phone: ______________________ Fax: ______________
Email: ______________________________

My signature below authorizes Restore Rx, Inc. staff to act as my authorized agent to complete the insurance prior authorization process for my patient listed above. My authorization shall include any required signatures by Restore Rx, Inc. Pharmacists on my behalf to facilitate this process and acknowledge their authorized access to necessary healthcare data to complete said process.

Physician Signature: ______________________________ Date: ______________

This prescription will be filled generically unless prescriber writes **"DAW"** in the box to the right.

fax referral to: **901-388-0407** | phone: **877-388-0507** | **www.restorerx.com**