Spravato® Enrollment Form

RESTORE Rx SPECIALTY PHARMACY

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 **Delivery Method:** Clinic delivery ONLY

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. ☐