Spravato® (esketamine) nasal spray

Date

Patient Referral for SPRAVATO® Treatment

ATTENTION TO:

RECEIVER FAX #:

Treatment Center Name

Phone Fax

Email

1. PATIENT INFORMATION

First Name: Last Name Date of Birth:

Address: Phone Number*:

Town/City: State: ZIP Code: Email:

*Can a voicemail be left at this number for an appointment? ☐Y/ ☐N

Primary Insurance: Policy #: Group #:

Policyholder Name: Card/BIN #:

Caregiver's Name: Caregiver's Phone Number:

Reminder: Please fax a copy of the insurance card with this referral. Your patient may have 2 insurance cards for pharmacy and/or medical benefit.

2. MEDICAL HISTORY

Diagnosis:

Medical/Treatment History: **Medication History:**

Additional medical reports and supporting documents are included with this form. ☐Y/ ☐N

3. REFERRING HEALTHCARE PROVIDER INFORMATION

Name: Phone Number:

Practice: Email: Fax Number:

Please notify me with updates regarding my patient through: ☐Phone/ ☐Email/ ☐Fax

Please see full Prescribing Information, including BOXED WARNINGS, and Medication Guide for SPRAVATO®.