Spravato Enrollment Form

e-Prescribe: NCPDP-1466033 |Fax Referral To: 1-844-850-7915 | Phone: 1-866-993-4779| Email Referral To: Customer.ServiceFax@CVSHealth.com

Six Simple Steps to Submitting a Referral

1 PATIENT INFORMATION (Patient must complete highlighted area) **Scheduled Administration Date: _____**

Patient Name: _____ Address: _____

City, State, ZIP Code: _____ DOB: _____ Last Four of SSN: _____ Gender: ☐ Male ☐ Female

Primary Phone: _____ Alternate Phone: _____ Email: _____

Parent/Caregiver/Legal Guardian Name (Last, First): _____ Relationship to patient: _____

Note: Carrier charges may apply. By providing the phone number(s) and email address above, you are consenting to receive automated calls, emails and/or text messages from CVS Specialty® about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone

Designated Patient Contact

By signing below, I authorize my Contact, listed below, to receive logistical and administrative information related to my treatment, including ability to make decisions on my behalf, for which I will remain liable, regarding delivery of Spravato (esketamine). CVS Specialty is not liable for any decision(s) made by the Contact or actions taken in reliance on such Contact decisions. Please list any authorized Contact as set forth above:

Contact Name: _____ Relationship: _____ Phone: _____

Patient's Signature: _____ Date: _____

2 PRESCRIBER INFORMATION

Facility Type: ☐ Private Practice ☐ Outpatient Hospital/Clinic ☐ Inpatient Facility ☐ Correctional

Prescriber's First Name: _____ Prescriber's Last Name: _____

NPI#: _____ State License#: _____ DEA#: _____

Practice/Facility Name: _____ Practice NPI#: _____

Practice Address (Ship to Address): _____ City: _____

State/ZIP Code: _____ Phone Number: _____ Fax Number: _____

Office Contact Name: _____ Contact's Phone: _____

3 HEALTH CARE SETTING INFORMATION

Health Care Setting Name: _____ Health Care Setting DEA#: _____

Address: _____ City, State, ZIP: _____

Phone: _____ Fax: _____ Contact Person: _____ Contact's Phone: _____

4 INSURANCE INFORMATION (Please fax copy of prescription/medical insurance cards with this form, front and back)

Is the Patient Insured? ☐ Yes ☐ No Is the Patient enrolled or eligible for Medicare/Medicaid? ☐ Yes ☐ No

Policy Holder's Name: _____ Policy Holder's DOB: _____ Relationship to Patient: _____

Medical Insurance: _____ Telephone: _____ Policy ID: _____ Group #: _____

Prescription Insurance: _____ Prescription Plan Telephone: _____

Policy ID: _____ Group #: _____ RX BIN #: _____ RX PCN #: _____

☐ Check box if patient is enrolled in manufacturer copay assistance If yes, please provide ID# _____

5 DIAGNOSIS AND CLINICAL INFORMATION (to be completed by prescriber only)

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

Patient Clinical Information:

Has patient previously been treated with ketamine for treatment-resistant depression, pain syndromes or any other condition?

☐ Yes ☐ No

If YES, list all pre-existing conditions treated with ketamine: _____

List all pre-existing medical and psychiatric conditions: _____

List concomitant medications (e.g., adjunctive depression medications, sedative hypnotics, psychostimulants, monoamine oxidase inhibitors [MAOIs]): _____

Allergies: _____

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6 PRESCRIPTION INFORMATION (to be completed by prescriber only)

Note: Spravato is available only through a restricted distribution program called the Spravato **Risk Evaluation and Mitigation Strategy** (REMS) because of the **risks of serious adverse outcomes resulting from sedation and dissociation caused by Spravato administration, and abuse and misuse of Spravato. Spravato is intended for patient administration under the direct observation of a health care provider, and patients are required to be monitored by a health care provider for at least 2 hours in a certified Health Care Setting.**

Is the patient currently enrolled in the Spravato REMS program? ☐ Yes ☐ No
Is the Health Care Setting currently enrolled in the Spravato REMS program? ☐ Yes ☐ No

***NOTE**: Prescriber must comply with his/her state-specific prescription requirements such as state-specific prescription forms, electronic prescribing requirements, product substitution or any other prescription element which may be required and that is not captured by this form. For this reason, the prescription form below should only be used if permitted by the applicable law in your state. The prescriber should include all required elements of a controlled substance prescription.*

Patient Name (First and Last): _____ Patient Date of Birth: _____

Patient Address:_____

Drug Name, Strength, and Dosage Form: _____

Directions/Sig: _____

Quantity Authorized (Numeric): _____ (Written): _____ Refills: _____

Prescriber Name: _____ Prescriber Phone Number:_____

Prescriber DEA #:_____ State License #: _____

Prescriber Address: _____

Supervising Physician Name: _____ Supervising Physician Phone Number:_____

Supervising Physician Address: _____ Supervising Physician DEA#: _____

6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

May Substitute/ Product Selection Permitted / Substitution Permissible	Dispense As Written/ Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute
Prescriber's Signature: _____ **Date: _____**	**Prescriber's Signature: _____** **Date: _____**

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "**No Substitution**"

ATTN: New York and Iowa providers, please submit electronic prescription

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

I have obtained written authorization from the Patient to disclose the Patient's personal health information and any other information on this enrollment form as may be required to comply with all applicable federal and state laws and regulations, including, but not limited to, the HIPAA Privacy Rule (45 C.F.R. Parts 160 and 164) and the Confidentiality of Substance Use Disorder Patient Records Regulation (42 C.F.R. Part 2), as amended from time to time.

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