



Spravato® Enrollment Form

Patient Data

Patient Name: _____ Birthdate: _____ Sex: Male Female Height: _____ Weight: _____ lbs kg
 SSN #: XXX-XX-____ Known Allergies: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: _____ Cell Phone: _____ Primary Language: _____
 Alternate Caregiver Name: _____ Phone of Caregiver: _____

Ins. Data

Primary Insurance: _____ Secondary Insurance: _____
 Policy: _____ Group#: _____ 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#

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

Clinical

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

Spravato®

Due to controlled substance guidelines in Pennsylvania please e-prescribe prescription
Surescript ID# CPR39961910791245818
If exempt from this guideline, please attach prescription copy and fax along with form.

Is patient new to this therapy: YES NO

Prescriber Data

Prescriber Name: _____ DEA#: _____ NPI: _____
 Practice Name: _____ Contact: _____
 Address: _____ Phone: _____ Fax: _____
 City: _____ State: _____ Zip: _____ Key Contact#: _____

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: **844-812-6227** | phone: **855-265-8008** | **www.vsprx.com**