Wellspring Health
INFUSION CENTER

SPRAVATO
Order Form
PHONE 563.900.8300 | **FAX** 563.900.8290

Please fax completed form, insurance card front/back, and clinical documentation to Wellspring

Patient Information

Patient Name: _____ Patient DOB:_____

Patient Address: _____City_____

State_____ ZIP_____ Primary Phone: _____

Gender: M__ F__ Patient Email: _____ Last Four of SSN: _____

Prescriber Information

Prescriber's Name: _____Credentials: __ MD __ DO __ NP __ PA Other: __

State License No: _____ NPI No: _____ DEA No: _____

Group or Hospital: _____

Specialty: __ Psychiatry __ Internal Medicine __ Family Practice __ Other: _____

Address: _____City_____

State_____ ZIP: _____ Phone: _____

Fax: _____Contact person: _____

Insurance Information

Primary Insurance: _____ Telephone: _____

Policy ID: _____ Group No: _____

Pharmacy Plan Name: _____ Pharmacy Plan Telephone: _____

Policy ID: _____ Group No: _____RX BIN No: _____ RX PCN No: _____

Diagnosis/Clinical Information

Diagnosis (ICD-10)

__ F33.1 Major Depressive Disorder, recurrent, moderate
__ F33.9 Major Depressive Disorder, recurrent, unspecified
__ 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
__ Other Code: _____ Description: _____

Patient Clinical Information

Has the patient previously been treated with ketamine for treatment-resistant depression, pain syndromes or any other condition? __ Yes __ No

If YES, please list all pre-existing conditions 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]):

_____

_____

Treatment Information for Prescribers

Spravato Prescribing Highlights

- Spravato must be administered in healthcare settings certified in the Spravato REMs program under the direct supervision of a healthcare provider to patients enrolled in the program.
- Recommended dosage for Spravato
    - **INDUCTION PHASE:** On day 1, administer 56 mg intranasally. For subsequent dosing during weeks 1 through 4, administer 56 mg or 84 mg 2x per week. Use 2 devices for the 56 mg dose and 3 devices for the 84 mg dose with a 5-minute rest between uses of each device.
    - **MAINTENANCE PHASE:** During weeks 5 through 8, administer 56 mg or 84 mg once weekly. During week 9 and thereafter, administer 56 mg or 84 mg every 2 weeks or once weekly.
    - The dosing frequency should be individualized to the least frequent dosing to maintain remission/response.

For additional information, please refer to full prescribing information: SPRAVATO Prescribing Information Website

Patient Checklist

- ❑ Must be 18 years or older
- ❑ Must be on antidepressant currently
- ❑ Must have a blood pressure of 140/90 or less
- ❑ At the completion of treatment patient must have a ride
- ❑ Must stay full 2 hours
- ❑ No history of aneurysm or vascular disease
- ❑ Can not be pregnant or planning to get pregnant, nor breast-feeding
- ❑ Must have 3 failed treatments
    - Ex: SSRI/SNRI
    - 1 adjunct (antipsychotic, lithium, TMS, etc.)
- ❑ Must have diagnosis of MDD
    - No psychosis
    - No single episode

- No cerebral hemorrhage or allergy to ketamine

❑ Needs depressive screening score (Becks preferred or PHQ9)

Prescription Information

Patient Name (First and Last): _____

Patient DOB: _____ Patient Allergies: _____

Spravato Strength and Dosage (56 mg or 84 mg):

Weeks 1-4 (Twice weekly) : 56 mg ___

Week 5-8 (Once Weekly) 56 mg ___**OR** 84 mg ___

Week 9-12: (Once every other week) 56 mg ___ 84 mg ___ **OR** (Once Weekly) 56 mg ___ 84 mg ___

Prescriber Name: _____ Prescriber DEA No: _____

Prescriber Address: _____

Physician's Signature: _____ Date: _____

Signature Required

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, I hereby authorize Wellspring Health and/or its affiliates to complete and submit prior authorization (PA) requests to payers for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.