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Spravato (esketamine) Clinician Referral Form and Requirements

Please complete the enclosed forms and fax with records to (214) 613-1667. The following are helpful in evaluating and obtaining a prior authorization:

☐ Patient Referral Form
☐ Copy of Insurance Card Front and Back
☐ Current and Previous Medication Records
☐ Most Recent Depression Measure (MADRS or PHQ-9)

After we receive your referral form, we will do the following:

- We will contact your patient to schedule a screening appointment and discuss treatment, answer preliminary questions, and collect any other relevant information needed.
- We will gather and submit the required documentation for prior authorization approval with insurance.
- We will update you when your patient is scheduled with us and again following initial treatment to share information regarding treatment response.

Spravato (esketamine) Clinician Referral Form

Referral Submission Date: _____

Patient Information

Name: _____ DOB: _____

Address: _____ City, State, Zip: _____

Phone: _____ Email: _____

Insurance Information

Insurance: _____ Cardholder Name: _____

Member ID: _____ Group #: _____

RX BIN: _____ RX PCN: _____

Clinical Information

☐ Treatment Resistant Depression (failed TWO or more antidepressants)
- ☐ F33.2 Major depressive disorder, Recurrent episode, Severe
- ☐ F33.1 Major depressive disorder, Recurrent episode, Moderate
- ☐ F32.2 Major depressive disorder, Single episode, Severe
- ☐ F32.1 Major depressive disorder, Single episode, Moderate
- ☐ Other: _____

☐ Major Depression with Suicidal Ideation

Estimated Date of Onset: _____

Medication History

Medication Name	Max Dose	Dates Started/Stopped	Result

Currently or Previously in Psychotherapy?

☐ Yes, Currently Provider Name: _____ Started: _____

☐ Yes, In Past Provider Name: _____ Dates: _____

Current Medications

Medication Name	Dose	Directions

Current Symptoms and Severity / Rationale for Treatment

Are any of the Following Conditions Present?

☐ None of the above are present

☐ History of aneurysmal vascular disease

☐ History of arterial venous malformation

☐ History of intracerebral hemorrhage

☐ History of cardiovascular disease

☐ History of Hypertension

☐ History of Substance Abuse

Referring Provider Information

Provider Name: _____ Phone: _____

Practice Name: _____ Fax: _____

Email: _____

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

Referring Provider Signature: _____ Date: _____

Please Fax Completed Form, Patient's Insurance Card, and Medication History to (214) 613-1667.