Patient Referral for Spravato™ Treatment **REFERRAL # REQUIRED**_____

***Indications for Treatment:** Patients 18 years or older with Treatment Resistant Depression (MDD patients who have had inadequate response to two or more AD's) or depressive symptoms in adults with MDD with acute suicide ideation or behavior (MDSI)

PATIENT INFORMATION

First Name: _____ Last Name: _____

Date of Birth: _____ Phone Number: _____

Address: _____Email Address: _____

Town/City: _____ State: _____ Zip Code: _____

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

Policyholder Name: _____ Card/BIN#:_____

Patient Diagnosis: _____ Treatment Resistant Depression (MDD patients who have had inadequate response to two or more AD's)
_____ MDD with acute suicide ideation or behavior (MDSI)

MEDICAL HISTORY

Important: All insurance companies require multiple failed classes of antidepressants. We will be unable to submit a Prior Authorization request for treatment if we do not receive a complete medication history INCLUDING dates (MM/YYYY), doses, reason for stopping medication (ie: side effects, lack of efficacy). ***Please include last appointment note and all medication history with referral.**

Medication	**Dose**	**Dates/Frequency** (ie: June/2022, present, weekly)	**Reason for Stop** (Please list side effects)

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

REFERRING HEALTHCARE PROVIDER INFORMATION

Name: _____ Phone Number: _____

Practice: _____ Email: _____ Fax #:_____

Please specify if/how you would like to receive updates regarding your patient: _____Phone _____Email _____Fax

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