Spravato Enrollment Form

CVS specialty®

Fax Referral To: 1-844-850-7915 **Phone:** 1-866-993-4779
Email Referral To: Customer.ServiceFax@CVSHealth.com

1 PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name: _____ Address: _____City, State, ZIP: _____
Preferred Contact Methods: ☐ Phone (to primary # provided below) ☐ Text (to cell # provided below)
☐ Email (to email provided below)
Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.
Primary Phone: _____ Alternate Phone: _____DOB: _____ Gender: ☐ Male ☐ Female
Email: _____ Last Four of SSN: _____ Primary Language: _____

2 PRESCRIBER INFORMATION

Prescriber's Name: _____ State License #: _____ NPI #: _____ DEA #: _____
Group or Hospital: _____ Credentials: ☐ MD ☐ DO ☐ NP ☐ PA ☐ Other _____
Specialty: ☐ Psychiatry ☐ Internal Medicine ☐ Family Practice ☐ Other_____
Address: _____ City, State, ZIP: _____
Phone: _____ Fax: _____ Contact Person: _____ 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 and insurance cards with this form, if available (front and back)

Primary Insurance Name: _____ Telephone: _____ Policy ID: _____ Group #: _____
Pharmacy Plan Name: _____ Pharmacy Plan Telephone: _____
Policy ID: _____ Group #: _____ RX BIN #: _____ RX PCN #: _____

5 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: _____

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

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 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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TREATMENT INFORMATION FOR PRESCRIBERS

Spravato prescribing highlights

- Spravato must be administered in health care settings certified in the Spravato REMS Program under the direct supervision of a health care provider to patients enrolled in the program.
- Recommended dosage for Spravato
  - INDUCTION PHASE: On day 1, administer 56 mg intranasally. For subsequent doses during weeks 1 through 4, administer 56 mg or 84 mg twice per week. Use two 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 two 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

6 PRESCRIPTION INFORMATION

Note: The prescription form below should only be used if permitted by the applicable law in your state and if you are not required by law to use an official/tamper-evident prescription form. 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) _____

Prescriber Name: _____ Prescriber DEA #:_____

Prescriber Address: _____

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 below, 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.

☐ Patient is interested in patient support programs

STAMP SIGNATURE NOT ALLOWED

Ancillary supplies and kits provided as needed for administration

6 PHYSICIAN SIGNATURE REQUIRED

PRODUCT SUBSTITUTION PERMITTED (Date)

X_____

DISPENSE AS WRITTEN (Date)

X_____

Note: Regulations around transmission of prescriptions for controlled substances vary state by state.