Spravato®
(esketamine)
nasal spray

Date

Patient Referral for SPRAVATO® Treatment

Treatment Center Name

Phone

Fax

Email

ATTENTION TO:

RECEIVER FAX #:

1. PATIENT INFORMATION

First Name:

Last Name

Date of Birth:

Address:

Phone Number*:

Town/City:

State:

ZIP Code:

Email:

*Can a voicemail be left at this number for an appointment? ☐Y/ ☐N

Primary Insurance:

Policy #:

Group #:

Policyholder Name:

Card/BIN #:

Caregiver's Name:

Caregiver's Phone Number:

Reminder: Please fax a copy of the insurance card with this referral. Your patient may have 2 insurance cards for pharmacy and/or medical benefit.

2. MEDICAL HISTORY

Diagnosis:

Medical/Treatment History:

Medication History:

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

3. REFERRING HEALTHCARE PROVIDER INFORMATION

Name:

Phone Number:

Practice:

Email:

Fax Number:

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

Please see full Prescribing Information, including BOXED WARNINGS, and Medication Guide for SPRAVATO®.