Hy-Vee health INFUSION CARE

SPRAVATO Enrollment Form

PHONE 515.225.2930 | **FAX** 515.559.2495

Patient Information

Fax completed form, insurance information and clinical documentation to 515.559.2495.

Patient Name: ________ **Patient Address:** ________ **City, State, ZIP:** ________

Preferred Contact Methods: Phone (to primary number provided below) Text (to cell number provided below) Email (to email provided below)

Note: Carrier charges may apply. If unable to contact via text or email, Hy-Vee Health will attempt to contact by phone.

Primary Phone: ________ **Alternate Phone:** ________ **DOB:** ________ **Gender:** Male Female

Email: ________ **Last Four of SSN:** ________ **Primary Language:** ________

Prescriber Information

Prescriber's Name: ________ **State License No:** ________ **NPI No:** ________ **DEA No:** ________

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:** ________

Healthcare Setting Information

Healthcare Setting Name: ________ **Healthcare Setting DEA No:** ________

Address: ________ **City, State, ZIP:** ________

Phone: ________ **Fax:** ________ **Contact Person:** ________ **Contact's Phone:** ________

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 No:** ________

Pharmacy Plan Name: ________ **Pharmacy Plan Telephone:** ________

Policy ID: ________ **Group No:** ________ **RX BIN No:** ________ **RX PCN No:** ________

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 healthcare provider, and patients are required to be monitored by a healthcare provider for at least 2 hours in a certified healthcare setting.***

Is the patient currently enrolled in the Spravato REMS program? Yes No

Is the healthcare 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: ________

Physician Information

By signing this form and utilizing our services, you are authorizing *Hy-Vee Health* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Provider Name: ________ **Signature:** ________ **Date:** ________

Provider NPI: ________ **Phone:** ________ **Fax:** ________ **Contact Person:** ________

Opt out of Hy-Vee Health selecting site of care (if checked, please list site of care): ________

Service Areas

Des Moines, IA West Des Moines, IA Chicago, IL Omaha, NE Buffalo, NY Dallas, TX Phoenix, AZ Other ________

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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 doses 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.

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 No:** ______________________

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 Hy-Vee Health 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.

PHYSICIAN SIGNATURE REQUIRED

Product Substitution Permitted ______________________ Date ______________________

Dispense as Written ______________________ Date ______________________

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

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