Center for Infusion Care
HILLSDALE HOSPITAL
Phone: (517) 212-4336 | **Fax:** (877) 249-1191
hillsdalehospital.com/infusion

☐ **STAT REFERRAL**

SPRAVATO ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI____ DOB:_____

HT: _____ in WT: _____ ☐ lbs ☐ kg Sex : ☐ Male ☐ Female Allergies: ☐ NKDA, _____

_____

Physician Name_____ Contact Name _____ Contact Phone # _____

NPI #:_____ Tax ID#:_____ Fax #: _____

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD 10 CODE + DESCRIPTION)

_____

Secondary Diagnosis: (ICD 10 CODE + DESCRIPTION)

_____

PERTINENT MEDICAL HISTORY

□ Depression Severity Score: _____ Date: _____

Rating Scale Used: _____

(e.g., Beck Depression Inventory [BDI], Hamilton Depression Rating Scale [HDRS], Montgomery-Asberg Depression Rating Scale [MADRS], etc.)

PRESCRIPTION ORDERS

SELECT	MEDICATION	DOSE	ROUTE	FREQUENCY	DURATION
☐	Spravato Induction Dose(s)	56 mg	Nasal Spray	Twice Every Week (Weeks 1-4)	4 Weeks
☐	Spravato Induction Dose(s)	84 mg	Nasal Spray	Twice Every Week (Weeks 1-4)	4 Weeks
☐	Spravato Maintenance Dose(s)	56 mg	Nasal Spray	Once Every Week (Weeks 5-8)	4 Weeks
☐	Spravato Maintenance Dose(s)	84 mg	Nasal Spray	Once Every Week (Weeks 5-8)	4 Weeks
☐	Spravato Maintenance Dose(s)	56 mg	Nasal Spray	Once Every 2 Weeks (Weeks 9 and after)	
☐	Spravato Maintenance Dose(s)	84 mg	Nasal Spray	Once Every 2 Weeks (Weeks 9 and after)	
☐	Spravato Maintenance Dose(s)	56 mg	Nasal Spray	Once Every Week (Weeks 9 and after)	
☐	Spravato Maintenance Dose(s)	84 mg	Nasal Spray	Once Every Week (Weeks 9 and after)	

SUPPORTING DOCUMENTATION FOR PATIENTS RECEIVING SPRAVATO:

1) **Treatment-Resistant Depression (TRD)**

- **Patients have a confirmed diagnosis of severe major depressive disorder (single or recurrent episode), documented by standardized rating scales that reliably measure depressive symptoms.**
- **Patients have experienced inadequate response during the current depressive episode with two antidepressants from at least two different classes with different mechanisms of action at the maximally tolerated labeled dose, each used for at least 8 weeks within the past 5 years.**
- **Patients have experienced an inadequate response with an adequate trial of augmentation therapy for at least 8 weeks within the past 5 years or evidenced based psychotherapy.**

2) **Major Depressive Disorder (MDD) with acute suicidal ideation or behavior**

- **Patients have major depressive disorder with current suicidal ideation with intent.**
- **The prescriber must present in the clinical documentation that, in the absence of the requested drug, within the next 24 to 48 hours the patient will require confinement in an acute care psychiatric institution; and the requested medication will be used in combination with an oral antidepressant.**

***Provider must enroll patient in the SPRAVATO REMS Program and provide enrollment confirmation documentation.**

***This medication must be prescribed by or in consultation with a psychiatrist**

***Spravato nasal spray is considered an exclusion for members with moderate or severe substance or alcohol use disorder that is not currently being treated or medically managed.**

***Augmentation therapy is defined as: two antidepressants with different mechanisms of action used concomitantly, an antidepressant and a second-generation antipsychotic used concomitantly, an antidepressant and lithium used concomitantly, or an antidepressant and thyroid hormone used concomitantly.**

Physician's Signature _____**Time**_____ **Date**_____
**Signature Must Be Clear and Legible*

Cosignature (If Required) _____ **Time**_____ **Date**_____
**Signature Must Be Clear and Legible*

Fax completed form, supporting documentation, facesheet, and insurance cards to the Outpatient Infusion Center at 1 (877) 249-1191.