Spravato® (esketamine) C III
28 mg nasal spray

Patient Referral for SPRAVATO® Treatment

PLEASE FAX COMPLETED FORM TO:

Diana Gallagher
Treatment Center Contact Name

Date

415-E Church St NW Ste 4 Huntsville AL 35801
Street Address Town/City State ZIP Code

256-489-0767
Phone Fax

diana@stlukeinc.com
Email

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:

2. MEDICAL HISTORY

Diagnosis:

Medical/Treatment History: **Medications History:**

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

Patient Signature for ROI (release of information):

3. REFERRING HEALTHCARE PROVIDER INFORMATION

Name: Phone Number:

Practice: Email: Fax Number:

Once we receive all the necessary documents, we may take steps to:

- **Contact your patient** to schedule a consultation, where we will discuss treatment, answer preliminary questions, and collect any additional information needed
- **Gather and submit documentation** for prior authorization with insurance
- **Complete a benefits investigation** and notify the patient of any anticipated out-of-pocket costs
- **Update you on your patient's treatment response and progress**

Our experienced and caring staff look forward to treating your patient!

Your patient may continue to see you for their general care. If you feel that your patient would benefit from seeing one of our clinicians for general care, please call us at the phone number given above to speak with our patient coordinator.

4. FAX INSTRUCTION

Send completed form to our **fax number**:

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