Spravato® (esketamine) C-III
28 mg nasal spray

Patient Referral for SPRAVATO® Treatment

PLEASE FAX COMPLETED FORM TO 918-588-8803

PARKSIDE PYCHIATRIC HOSPTAL & CLINIC **DATE:** _____
1239 South Trenton Avenue Tulsa, OK 74120-5420
Phone:918-588-8846 Fax: 918-588-8803
CONTACT: Lisa West lwest@parksideinc.org

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? ☐ YES ☐ NO

Primary Insurance: Group #:

Policy #:

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. ☐ YES ☐ NO

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 **918-588-8803**

Please see accompanying full Prescribing Information, Including BOXED WARNINGS, and Medication Gulde for SPRAVATO®.

Spravato Patient Enrollment and Weekly Addendum

Date: _____

Name:_____Chart#_____

Date of Birth:_____Allergies:_____

Current Diagnosis:

_____

_____

Health Conditions:

_____

_____

History of High Blood Pressure in your immediate family: No or Yes

Relationship to you:_____

Names of current prescription and over the counter medications:

_____

_____

_____

History of substance use:_____

Have you taken your medications today: Yes or No

Have you eaten today: Yes or No

Vitals: RR___ PN___ HT___ WT____ TEMP___ _

Start Time* 1st dose 2nd dose 3rd dose 40 min* 120 min*

_____ _____ _____ _____ _____ _____

*BP+HR__ __/__ __/__ __*BP+HR__ __/__ __/___ *BP+HR___/____ /___

PATIENT HEALTH QUESTIONNAIR E (PHQ-9)

ID#:_____ **DATE·**_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use numerals to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	

TOTAL:

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

1O. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____

Medication Trials

Name:_____ **Date**_____

Please check all medications you have taken in the past. Please note if they were beneficial. If not, please note why you feel the medication didn't work and add the start and end dates you took the medication.

- ☐ Acaprosate/Campral
- ☐ AgomelatineNaldoxan
- ☐ Amitriptyline/Elavil
- ☐ Amoxapine
- ☐ Aripiprazole/Abilify
- ☐ Armodafinil/Nuvigil
- ☐ Asenapine/Saphris
- ☐ Atomoxetine/Strattera
- ☐ Blonanserin/Lonasen
- ☐ Brexpiprazole/Rexulti
- ☐ Buprenorphine/Suboxone
- ☐ Bupropion/Wellbutrin
- ☐ Buspirone/Buspar
- ☐ CariprazineNraylar
- ☐ Chlorpromazine/Thorazine
- ☐ Citalopram/Celexa
- ☐ Clomipramine/Anafranil
- ☐ Clozapine/Clozaril
- ☐ Desipramine
- ☐ Desvenlafaxine/Pristiq
- ☐ Disulfiram/Antabuse
- ☐ Doxepin/Silenor
- ☐ Duloxetine/Cymbalta
- ☐ Escitalopram/Lexapro
- ☐ Esketamine/Spravato
- ☐ Eszopiclone/Lunesta
- ☐ Fluoxetine/Prozac
- ☐ Fluphenazine/Prolixin
- ☐ Fluvoxamine/Luvox
- ☐ Gabapentin/Neurontin
- ☐ Haloperidol/Haldol
- ☐ HydroxyzineNistaril
- ☐ Iloperidone/Fanapt
- ☐ Imipramine
- ☐ Isocaboxazid
- ☐ Lamotigine/Lamictal
- ☐ Levomilnacipran/Fetzima
- ☐ Lithium
- ☐ 1-methylfolate
- ☐ lofepramine
- ☐ Lumateperone/Caplyta
- ☐ Lurasidone/Latuda

Medication trials

Name: _ _ _ _ _ _ _ _ _ _ _ _ **Date**_____

Please check all medications you have taken in the past. Please note if they were beneficial. If not, please note why you feel the medication didn't work and add the start and end dates you took the medication.

- ☐ Maprotiline
- ☐ Mianserin/Lerivon
- ☐ Milnacipran
- ☐ Mirtazapine/Remeron
- ☐ Moclobemide
- ☐ Modafinil/Provigil
- ☐ NaltrexoneNivitrol
- ☐ nefazodone
- ☐ nortriptyline
- ☐ Olanzapine/Zyprexa
- ☐ Paliperidone/Invega
- ☐ Paroxetine/Paxil
- ☐ Perphenazine
- ☐ Phenelzine/Nardil
- ☐ Prazosin/Minipress
- ☐ Protriptyline
- ☐ Quetiapine/Seroquel
- ☐ Ramelteon
- ☐ Reboxetine
- ☐ Risperidone/Risperdal
- ☐ selegiline
- ☐ Sertraline/Zoloft
- ☐ Solriamfetol/Sunosi
- ☐ Sulpiride
- ☐ Suvorexant/Belsomra
- ☐ Thioridazine
- ☐ Thiothixene/Navane
- ☐ Tianeptine
- ☐ Topiramate/Topamax
- ☐ Tranylcypromine
- ☐ Trazodone
- ☐ Trifluoperazine
- ☐ Triiodothyronine/Cytomel
- ☐ Trimipramine
- ☐ Valproate/Depakote
- ☐ Varenicline/Chantix
- ☐ Venlafaxine/Effexor
- ☐ VilazodoneNiibryd
- ☐ Vortioxetine/Trintellix
- ☐ Zaleplon/Sonata
- ☐ Ziprasidone/Geodon
- ☐ Zolpidem/Ambien

SPRAVATO® REMS

Patient Enrollment Form .. Outpatient. Use Only

This section is to be completed by the Patient

Your healthcare provider will help you complete this form and provide you with a copy.

• *Indicates required field*

Patient Information

First Name*:	MI:	Last Name*:	Birthdate*: (MM/DD/YYYY):	Sex*: ☐ Male ☐ Female ☐ Other
Email': (Email Is required lor onllne enrollment only)			Phone Number•:	
Address 1•:			Address 2:	
City*:		State*:	ZIP*:	

Patient Agreement

By signing this form, I understand and acknowledge that:

Before my treatment begins, I will:

- Enroll in the SPRAVATO® REMS by completing this *Patient Enrollment Form* with my healthcare provider. Enrollment Information will be submilted to the SPRAVATOI> REMS.
- Receive counseling on safety risks and the need for monitoring to observe for resolution of sedation and dissociation, and for any changes in vital signs.

During treatment. and after administration, I will:

- Use the SPRAVAT0° nasal spray myself under the direct observation of a healthcare provider.
- Be observed at the healthcare setting where I get SPRAVATO® for at least 2 hours after each treatment until the healthcare provider determines I am ready to leave the healthcare setting.

I understand:

- Sedation and dissociation can result from treatment with SPRAVATOI• and I must stay after each treatment.
  Until these effects resolve, I may feel:
  - sleepy and/or
  - disconnected from myself, my thoughts, feelings and things around me.
- I should make arrangements to safely get home.
- I should not drive or use heavy machinery for the rest of the day on which I receive SPRAVATO®.
- I should contact my doctor or inform him/her at my next visit If I believe I have a side effect or reaction from SPRAVATO®.
- In order to receive SPRAVATO® as an outpatient, I am required to be enrolled In the REMS, and my information will be stored in a database of all outpatients who receive SPRAVATO® In the United States.
- Janssen Pharmaceuticals, Inc. and its agents, including trusted vendors, may contact me or my prescriber via phone, mall, fax, or email to support administration of the REMS.
- Janssen Pharmaceuticals, Inc. and its agents, including trusted vendors, may use, disclose, and share my personal health Information for the purpose of the operations of the REMS, including enrolling me into the REMS and administering the REMS, coordinating the dispensing of SPRAVATO®, and releasing and disclosing my personal health information to the Food and Drug Administration (FDA), as necessary, and as otherwise required by law.

Patient Name (please print):

Patient Signature':	Date •:

What should I avoid while taking SPRAVATO ?

Do not drive, operate machinery, or do anything where you need to be completely alert after taking SPRAVATO®.

Do not take part in these activities until the next day following a restful sleep.