SPRAVATO REFERRAL FORM

PHONE 888.370.1724 | **FAX** 877.645.7514

AMBER™ SPECIALTY PHARMACY

Remove above portion before faxing. Please complete the prescription form in its entirety and fax with secure cover sheet to the number above.

PATIENT INFORMATION

Patient Name (Last, First)	DOB	Gender ☐ M ☐ F	Last 4 SSN	Primary Language
Address	City	State	ZIP	
Email	Home Phone	Work Phone	Cell Phone	
Primary Contact Method ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Text ☐ Email ☐ DO NOT CONTACT				
Primary Caregiver Name	Caregiver Email	Caregiver Phone		
Anticpated Start Date	Patient Height (cm/in)	Patient Weight (kg/lbs)	Date Obtained	
Allergies ☐ NKDA ☐ Drug Allergies (please list) ☐ Other (please list)				
Therapies Tried and Failed (please list medications)				

ICD-10 Code

☐ F33.0 Major depressive disorder, recurrent, mild
☐ F33.1 Major depressive disorder, recurrent, moderate
☐ F33.2 Major depressive disorder, recurrent, severe w/o phychotic features
☐ F33.3 Major depressive disorder, recurrent, severe w phychotic features
☐ 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
☐ F33.8 Other recurrent depressive disorders
☐ Other (please list)

** Please include a copy of the **front and back of insurance card** & **applicable clinical chart notes** **

PRESCRIBER INFORMATION

Name of Referral Contact	Title	Preferred Contact Method ☐ Email ☐ Phone ☐ Fax	
Referral Contact Email	Office Phone	Office Fax	
Practice Name	Prescriber Name	NPI #	
Address	City	State	ZIP

PRESCRIPTION INFORMATION

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state-specific required language to prohibit substitutions. This form is not a valid prescription form for writing controlled medications.

MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
☐ SPRAVATO				
☐ SPRAVATO (for MSDI only)				

Prescriber Signature _____ Date _____ Supervising Physician Signature (where required by state law) _____ Date _____

DAW (Dispense as Written) _____ Date _____ Brand Necessary (must handwrite) _____

— If the state requires eprescriptions for controlled substances this form is not valid —

Note: *The information contained in this document will become a legal prescription. Prescriber is to comply with his/her state specific Pharmacy and Medical Board guidelines such as e-prescribing, state specific prescription form, fax language, number of prescriptions allowed on a single prescription form, etc. If more than one page is required, make additional copies. Non-compliance with state specific requirements could result in outreach to the prescriber.*

REV:07/29/24