

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 <input type="checkbox"/> M <input type="checkbox"/> F	Last 4 SSN	Primary Language
Address			City	State	ZIP
Email	Home Phone		Work Phone		Cell Phone
Primary Contact Method <input type="checkbox"/> Cell Phone <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/> DO NOT CONTACT					
Primary Caregiver Name		Caregiver Email		Caregiver Phone	
Anticipated Start Date		Patient Height (cm/in)	Patient Weight (kg/lbs)	Date Obtained	
Allergies <input type="checkbox"/> NKDA <input type="checkbox"/> Drug Allergies (please list) <input type="checkbox"/> Other (please list)					
Therapies Tried and Failed (please list medications)					
ICD-10 Code					
<input type="checkbox"/> F33.0 Major depressive disorder, recurrent, mild <input type="checkbox"/> F33.1 Major depressive disorder, recurrent, moderate <input type="checkbox"/> F33.2 Major depressive disorder, recurrent, severe w/o psychotic features <input type="checkbox"/> F33.3 Major depressive disorder, recurrent, severe w psychotic features <input type="checkbox"/> F33.9 Major depressive disorder, recurrent, unspecified		<input type="checkbox"/> F33.40 Major depressive disorder, recurrent, in remission, unspecified <input type="checkbox"/> F33.41 Major depressive disorder, recurrent, in partial remission <input type="checkbox"/> F33.42 Major depressive disorder, recurrent, in full remission <input type="checkbox"/> F33.8 Other recurrent depressive disorders <input type="checkbox"/> 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 <input type="checkbox"/> Email <input type="checkbox"/> Phone <input type="checkbox"/> 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
<input type="checkbox"/> SPRAVATO				
<input type="checkbox"/> 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.

Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately at the address and telephone number set forth herein and obtain instructions as to proper destruction of the transmitted material.