Kaur Psychiatric Associates, PA
3300 Battleground Ave #100
Greensboro, NC 27410
Phone (336) 645-9555 Fax (866) 324-5202
KaurPsychiatric.com

Spravato Referral Forms and Requirements

Patient Name: _____ Date of Birth: _____

Phone Number: _____ Insurance Co: _____

Please fill out all forms completely and make sure to include:

- ☐ Forms to be filled out completely
  - ☐ Spravato REMS Enrollment Form (two pages)
  - ☐ Current and Previous Medication List
  - ☐ Physician Referral Form (including office contact info)
- ☐ Copy of Insurance Card Front and Back
- ☐ Copy of Picture ID (state ID, passport, driver's license, etc)
- ☐ Copy of Currently Approved Prior Authorization

Physician Spravato Referral Form

Date: _____

Patient Name: _____

Date of Birth: _____

I am referring my patient to Kaur Psychiatric Associates, PA for treatment of Major Depressive Disorder with the medication Spravato. I understand that they will remain under my care and will only be receiving the medication Spravato. The patient will continue treatment at my practice for all other needs, including paperwork, refills, medication changes, and other routine services.

It is my professional opinion that this patient meets the criteria to receive treatment with Spravato.

_____

Physician's Signature

_____

Physician's Printed Name

_____

Physician's Office Name

_____

Physician's Office Phone Number

Current and Previous Medications Used to Treat Depression

Patient Name:_____ Date of Birth_____

Medication Name	Dose	Start Date	End Date	Current
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Spravato® (esketamine) nasal spray

SPRAVATO® REMS

Johnson&Johnson

Patient Enrollment Form - Outpatient Use Only

INSTRUCTIONS:

This form is intended only for use by outpatient medical offices or clinics, excluding emergency departments

1. Complete this form online at www.SPRAVATOrems.com.

This section is to be completed by the Prescriber

**** Indicates required field***

Healthcare Setting Information

Healthcare Setting Name*: Kaur Psychiatric Associates, PA		
Healthcare Setting DEA License Number* (associated with the Healthcare Setting address): BK2475831		
Address 1*: 3300 Battleground Ave #100	Address 2:	
City*: Greensboro	State*: NC	ZIP*: 27410
Phone*: 336-645-9555	Fax*: (866) 324-5202	

Prescriber Information

First Name*: Rupinder	Last Name*: Kaur	
Credentials*: ☑ Physician ☐ Physician Assistant ☐ Nurse ☐ Pharmacist ☐ Other _____ Specialty*: ☑ Psychiatry ☐ Internal Medicine ☐ Family Practice ☐ Other _____		Prescriber DEA License Number*: BK2475831
Phone*: 336.645-9555	Fax: (866) 324-5202	Email*: N/A
Prescriber Signature*:		Date*:

Referring Healthcare Provider – if different from Prescriber

First Name:	Last Name:

Relevant Clinical Information

List all pre-existing medical and psychiatric conditions*:

_____

_____

List concomitant medications (e.g.,CNS depressants, adjunctive depression medications, sedative hypnotics, psychostimulants, monoamine oxidase inhibitors [MAOIs])*:

_____

_____

Healthcare providers should report suspected adverse events or product quality complaints associated with SPRAVATO® to Janssen Pharmaceuticals, Inc., a Johnson & Johnson Company at 1-800-526-7736 or the FDA at 1-800-FDA-1088 or online at www.fda.gov/medwatch.

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Spravato® (esketamine) nasal spray

SPRAVATO® REMS

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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 for online 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:

- Receive counseling from a healthcare provider on:
  - The risk of sedation, dissociation, and respiratory depression.
  - The need for monitoring for resolution of sedation, dissociation, respiratory depression, and other changes in vital signs.
  - The need to have arrangements to safely leave the healthcare setting and not engage in potentially hazardous activities.
- For outpatients: Enroll in the REMS by completing the **Patient Enrollment Form** with a healthcare provider. Enrollment information will be provided to the REMS.

During treatment, before each dose I will:

- Receive counseling from a healthcare provider on the requirement for monitoring for resolution of sedation, dissociation, respiratory depression, and other changes in vital signs, and the need to have arrangements to safely leave the healthcare setting and not engage in potentially hazardous activities.

During treatment, during and after administration for at least two hours I will:

- Be monitored for taking SPRAVATO®, resolution of sedation, dissociation, respiratory depression, and other changes in vital signs at the healthcare setting.

I understand:

- I understand that my protected health information will be stored in a secure and confidential database and shared for the management of the REMS.
- I understand that Janssen Pharmaceuticals, Inc. and its agents, may contact me or my prescriber via phone, mail, fax, or email to support administration of the REMS.
- I give permission to Janssen Pharmaceuticals, Inc and its agents to use and share my personal health information for the purposes of enrolling me into the REMS and administering the REMS, coordinating the dispensing of SPRAVATO®, and releasing my personal health information to the Food and Drug Administration (FDA) as necessary.

Patient Name (please print):	
Patient Signature*:	Date*:

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