



SpecialtyRx.GiantEagle.com  
1-844-259-1891

## Patient Information

New Patient  Current Patient

### Patient's Name

First \_\_\_\_\_ Last \_\_\_\_\_ MI \_\_\_\_\_

Male  Female

Last 4 digits of SSN \_\_\_\_\_ Date of Birth \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Preferred Phone \_\_\_\_\_  Landline  Mobile

Alternate Phone \_\_\_\_\_  Landline  Mobile

Preferred Method of Contact  Call  Text

Email Address \_\_\_\_\_

Patient's Primary Language  English  Other If other, please specify \_\_\_\_\_

**Parent/Guardian Name (if under 18)** \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email Address \_\_\_\_\_

**Alternate Caregiver/Contact** \_\_\_\_\_

OK to speak to/leave message with alternate caregiver/contact

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email Address \_\_\_\_\_

**PLEASE ATTACH COPY OF FRONT AND BACK OF PATIENT'S INSURANCE CARD**



## Prescriber Information

Date Prescription Needed \_\_\_\_\_

Ship to Office  Patient Pickup at Retail  Ship to Home

Office Hours to Receive Shipment of Medication \_\_\_\_\_

Office Contact and Title \_\_\_\_\_

Office Contact Phone \_\_\_\_\_

**Patient's Name**

First \_\_\_\_\_ Last \_\_\_\_\_ MI \_\_\_\_\_

Date of Birth \_\_\_\_\_

Street Address \_\_\_\_\_

Address Line 2 \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Primary ICD-10 code \_\_\_\_\_ Has the patient been on this therapy before?  Yes  No

NKDA  Known drug allergies \_\_\_\_\_

Concurrent Medications \_\_\_\_\_

**Prescribing Information**

Medication	Strength	Directions	Qty/Refills
<input type="checkbox"/> Spravato (esketamine) CIII nasal spray	84mg Kit	<input type="checkbox"/> Instill 84mg intranasally once weekly Controlled substance will be delivered by the pharmacy to the practitioner, at his/her registered location for administration to the patient  <input type="checkbox"/> Instill 84mg intranasally twice weekly Controlled substance will be delivered by the pharmacy to the practitioner, at his/her registered location for administration to the patient  <input type="checkbox"/> Instill 84mg intranasally every other week Controlled substance will be delivered by the pharmacy to the practitioner, at his/her registered location for administration to the patient	Qty: <input type="checkbox"/> 1 kit <input type="checkbox"/> 2 kits <input type="checkbox"/> 4 kits <input type="checkbox"/> 8 kits Refills: 0 or specify below _____

- Spravato® prescriptions are shipped only to the prescriber’s healthcare setting address as listed on their DEA registration and is never dispensed directly to patients.
- Spravato® can only be obtained through REMS-certified pharmacies; please visit [www.spravatorems.com](http://www.spravatorems.com) for further information.
- All prescriptions for Spravato® should be sent directly to the REMS-authorized dispensing pharmacy. For patient support and program information, please visit the manufacturer’s product support website [www.spravato.com](http://www.spravato.com).

This form is provided for informational and convenience purposes only. The completion of this form by a prescriber may not constitute a valid prescription in accordance with state law. The pharmacy may contact the prescriber upon receipt of this enrollment form in order to obtain a valid prescription under state law.

Prescriber Name \_\_\_\_\_

State License \_\_\_\_\_ DEA \_\_\_\_\_ NPI \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ Email Address \_\_\_\_\_

Facility Name \_\_\_\_\_ Facility DEA# \_\_\_\_\_

Office Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

I hereby authorize Giant Eagle to contact my prescribing provider to coordinate the delivery, receipt, and storage of my prescription medication for the sole purpose of administration by my provider at my next scheduled appointment. Signature serves as Patient Ship Authorization.

Patient authorization signature \_\_\_\_\_

In order for brand name to be dispensed, prescriber must hand write "Brand Medically Necessary" or "Brand Necessary" in the space below:

\_\_\_\_\_

I authorize this prescription and for Giant Eagle Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

Prescriber signature required. NO STAMPS. Prescriber attests this is his/her legal signature.

Prescriber signature \_\_\_\_\_ Date \_\_\_\_\_