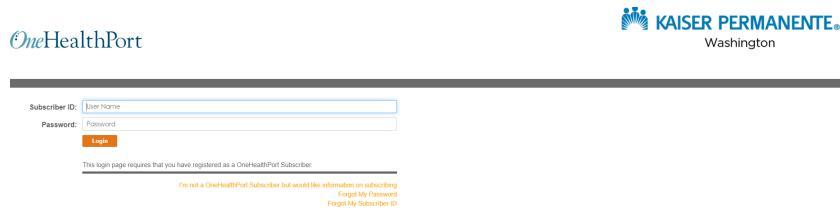
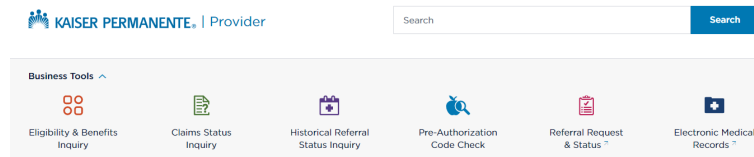


JOB AID: Mental Health & Wellness Providers Requesting Authorizations via Referral/Order Entry **(NOT FOR ABA PROVIDERS)**

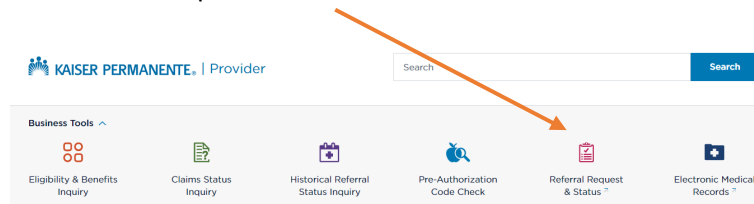
1. Log in via OneHealthPort
 - a. Select Kaiser Permanente Washington from the available provider options
 - b. Enter your current OneHealthPort user ID and password



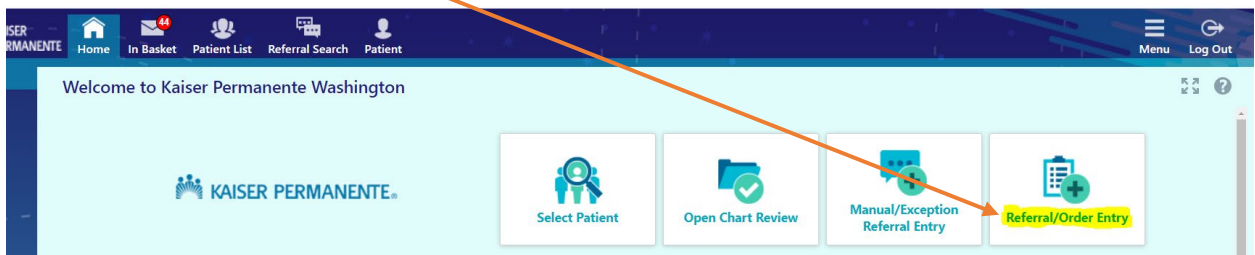
The new navigation toolbar can be used to initiate key activities like checking benefits eligibility or following up on claim status



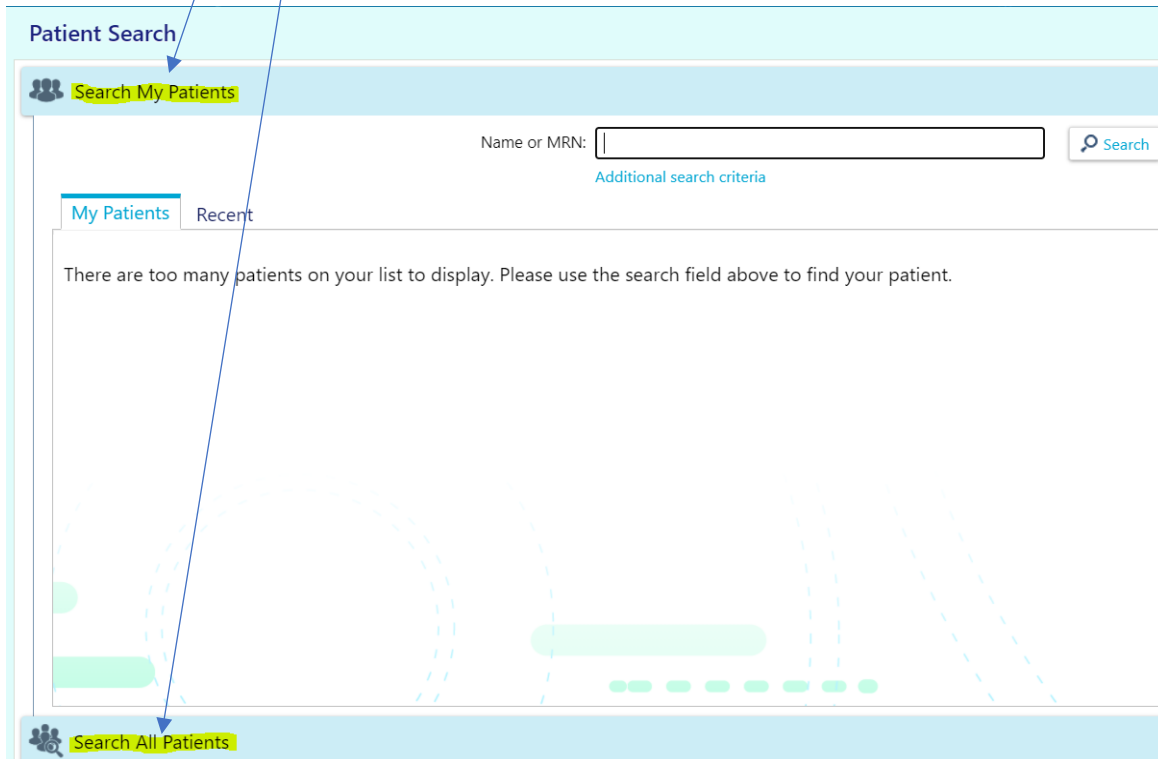
- c. Select the Referral Request & Status Tool to access the Affiliate Link Referral Tool



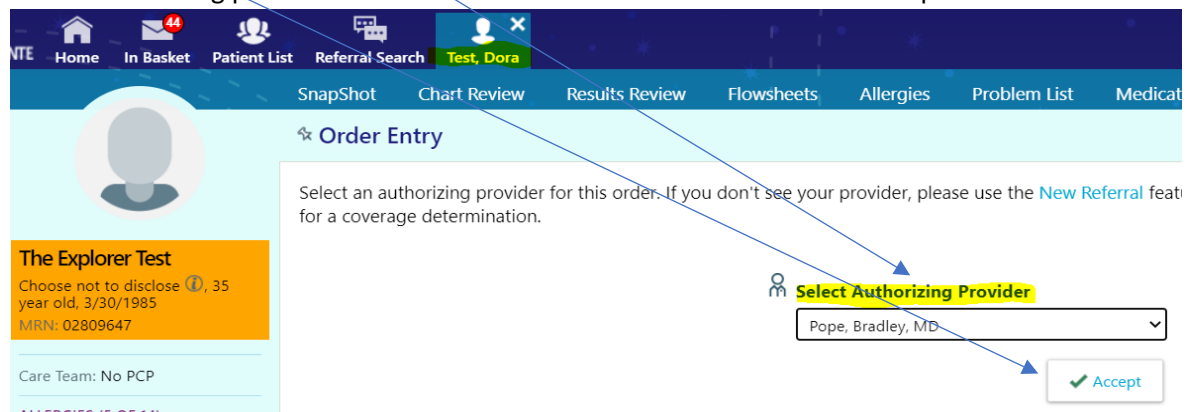
2. Select the Referral/Order Entry tool to begin requesting an initial or reauthorization request



3. Select patient from either Search My Patients or Search All Patients
 - a. Search My Patients – Use this function to search your loaded patient list. Patients can be loaded to a patient list if they have an approved authorization or if added by the contracted provider using the Search All Patients and adding to the Patient list
 - b. Search All Patients – Use this function to search the entire Kaiser Permanente system for patients and to select them to add to a patient list.



4. Once a patient is selected, they will show in the top tool bar and will remain selected until a different patient is selected
5. Select Authorizing Provider – This is the Provider who is “ordering/requesting” the services. Click Accept.
 - a. If a provider is not showing in the Select Authorizing Provider drop down, please email KPWA.provider-services@kp.org and include the provider name, tax id and individual NPI of the missing provider. We will research the issue and submit it for an update.



6. Fill in the New procedure field: This is the Referral Template type being requested.

Order Entry

Preference List Dx Association

New procedure:

Order Entry

Preference List Dx Association

New procedure:

7. We have several templates available. Within those templates, there are two templates for Mental Health and Wellness Providers to utilize. Select the one that is appropriate for the services.

- a. REF Mental Health (FOR MH PROVIDERS ONLY)
- b. REF Mental Health (FOR MH PROVIDERS ONLY) – TO KAISER MENTAL HEALTH & WELLNESS
- c. REF Chemical Dependency (FOR CD PROVIDERS ONLY)

Please make a selection

Procedure:

My Preference List Matches:

| Name | Px Code | Type | Priority | Status | Pref List |
|---|-----------|----------|----------|--------|-----------------------------|
| REF MENTAL HEALTH (FOR PRIMARY CARE PROVIDERS) | 90806.102 | Referral | | | KPWA AL REFERRAL PROCEDURES |
| REF MENTAL HEALTH (FOR MH PROVIDERS ONLY) | 99214.102 | Referral | | | KPWA AL REFERRAL PROCEDURES |
| REF MENTAL HEALTH - (FOR PRIMARY CARE PROVIDERS) TO KAISER MENTAL HEALTH & WELLNESS | 90806.101 | Referral | | | KPWA AL REFERRAL PROCEDURES |
| REF MENTAL HEALTH (FOR MH PROVIDERS ONLY) - TO KAISER MENTAL HEALTH & WELLNESS | 99214.101 | Referral | | | KPWA AL REFERRAL PROCEDURES |
| REF SUBSTANCE USE DISORDER TREATMENT (FOR PCP) - TO KAISER MENTAL HEALTH & WELLNESS | 99201.425 | Referral | | | KPWA AL REFERRAL PROCEDURES |
| REF SUBSTANCE USE DISORDER TREATMENT (FOR SUD/MH PROVIDERS ONLY) - TO KAISER MENTAL HEALTH & WELLNESS | 99201.424 | Referral | | | KPWA AL REFERRAL PROCEDURES |

Please make a selection

Procedure:

My Preference List Matches:

| Name | Px Code | Type | Priority | Status | Pref List |
|---|-----------|----------|----------|--------|-----------------------------|
| REF SUBSTANCE USE DISORDER TREATMENT (FOR SUD/MH PROVIDERS ONLY) - EXTERNAL (aka CHEMICAL DEPENDENCY) | 99214.104 | Referral | | | KPWA AL REFERRAL PROCEDURES |
| REF SUBSTANCE USE DISORDER TREATMENT (FOR SUD/MH PROVIDERS ONLY) - TO KAISER MENTAL HEALTH & WELLNESS (aka CHEMICAL DEPENDENCY) | 99201.424 | Referral | | | KPWA AL REFERRAL PROCEDURES |
| REF SUBSTANCE USE DISORDER TREATMENT EXTERNAL (aka CHEMICAL DEPENDENCY) | 99214.103 | Referral | | | KPWA AL REFERRAL PROCEDURES |
| REF SUBSTANCE USE DISORDER TREATMENT - TO KAISER MENTAL HEALTH & WELLNESS (aka CHEMICAL DEPENDENCY) | 99201.425 | Referral | | | KPWA AL REFERRAL PROCEDURES |

8. Once a template is selected, the Order will be opened.

9. Class: External will auto populate. If referring internal to Kaiser Permanente Mental Health & Wellness use that template

10. To prov spec: This field will auto populate with Mental Health Counseling. NOTE: If the specialty/organization is Psychiatric Nurse Practitioner, change this field to Psychiatric Nurse Practitioner here.

11. Select To provider: Enter the Organization Name in this Field. This field is very important, as this information attaches the authorization to your Tax ID. The address will display as the billing address for the organization.

12. To loc/pos: Enter/Select the Care Site or Location where patient will be seen
 b. If you do not locate your organization or location, please use our troubleshooting tool to submit the information so we can research the system setup. Troubleshooting Form Link: [Affiliate Link Issue Troubleshooting Form](#)

REF MENTAL HEALTH (FOR MH PROVIDERS ONLY)

Process instructions: This order is for Mental Health providers' use. If you are not a Mental Health provider, remove this order and place an order using "REF MENTAL HEALTH"

External MH providers: Choose "External" for class if you are requesting auth/reauthorization. Please be sure to enter your practice site for either "To provider" or "To loc/pos" section and verify that information is correct. Authorization will be generated to the provider/site entered here, if it is approved. If you are referring the patient to a Kaiser staff provider, choose "Internal".

Referral: Priority: Routine [1] Routine Urgent

To prov spec: Mental Health Counseling [283]

⚠ To provider: [Redacted]

Address [Redacted]

⚠ To loc/pos: [Redacted]

REF MENTAL HEALTH (FOR MH PROVIDERS ONLY)

Process instructions: This order is for Mental Health providers' use. If you are not a Mental Health provider, remove this order and place an order using "REF MENTAL HEALTH"

External MH providers: Choose "External" for class if you are requesting auth/reauthorization. Please be sure to enter your practice site for either "To provider" or "To loc/pos" section and verify that information is correct. Authorization will be generated to the provider/site entered here, if it is approved. If you are referring the patient to a Kaiser staff provider, choose "Internal".

Referral: Priority: Routine [1] Routine Urgent

To prov spec: Psychiatric Nurse Practitioner [31]

⚠ To provider: [Redacted]

Address [Redacted]

⚠ To loc/pos: [Redacted]

13. Questions: Depending on the service selected, the corresponding questions will appear below. See examples of the questions at the end of this job aid for more detailed screen shots.

14. Comment: This field will not be reviewed for coverage determination but can be used to add comments that may support the request.
15. DX Association: Enter Diagnoses in this field. Multiple diagnoses may be selected. Enter either the DX code or name and select the most appropriate code. You may be asked to answer specific questions related to the diagnosis code selected if the code selected is not specific enough for billing.
16. Attach files: You may upload documents to support your request. Document size max is 100.0 MB. The system will recognize the following file types: .jpg, .png, .doc, docx, .tiff
17. Accept: Click this button when the all fields are complete. This will place the Order in your “Unsigned Orders List”.

Questions:

| Questions: | Answer |
|------------------------------------|----------------------------------|
| 1. Reason for Referral: | <input type="text"/> |
| 2. What is the reason for request? | <input type="text"/> |
| 3. Requested Place of Service? | Office [11] <input type="text"/> |

Comment:

Dx association:

| Recent | |
|--------------------------|--|
| <input type="checkbox"/> | Lesion of eyelid H02.9 |
| Quick Picks | |
| <input type="checkbox"/> | Acute gout due to renal impairment involving left foot M10.372 |
| <input type="checkbox"/> | Allergic rhinitis J30.9 |
| <input type="checkbox"/> | Cancer of axillary tail of breast C50.619 |

Add a new diagnosis:

Attach files:

Add files

100.0 MB Total Allowed 0 Files ⓘ

18. Unsigned new orders: This list has not been transmitted to our referral team. You can edit the order by clicking the pencil or delete it with the trash can.
19. If an order has a red circle with an exclamation point, the order has unresolved fields and will not be able to be signed/transmitted without resolving them. Click edit and find the red stop sign fields to complete them before signing the order.

Unsigned new orders (1)

| | |
|--|---|
| <div style="display: flex; align-items: center;"> ⓘ REF MENTAL (FOR MH PROVIDERS ONLY) </div> <p style="margin-top: 5px;">External</p> | <input type="text"/> ✎ 🗑️ |
|--|---|

Orders signed in this encounter (2)

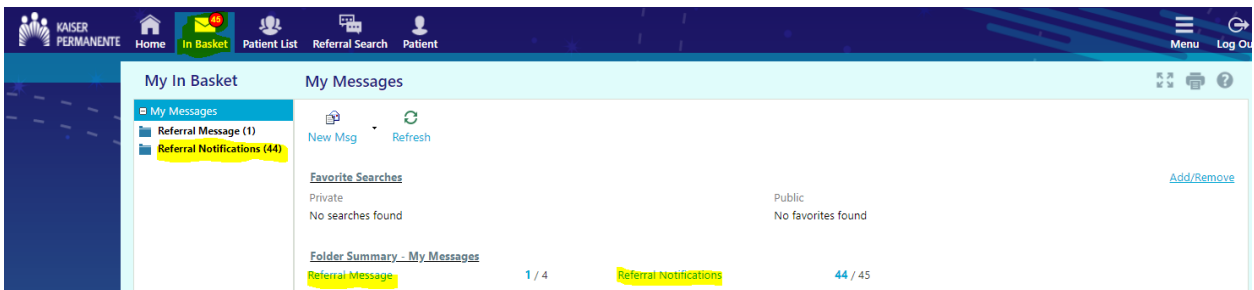
20. Once all issues are resolved, click Sign Orders at the bottom to submit the request.



The screenshot displays a web interface for managing orders. At the top, there is a section titled "Unsigned new orders (1)" containing one item: "REF MENTAL (FOR MH PROVIDERS ONLY) External". Below this is a section titled "Orders signed in this encounter (2)" containing two items: "REF CARDIOLOGY Scheduling needed. External" and "REF PODIATRY Scheduling needed. External". At the bottom right of the interface, there is a yellow button with a checkmark icon and the text "Sign Orders". A blue arrow points from the text in step 20 to this button.

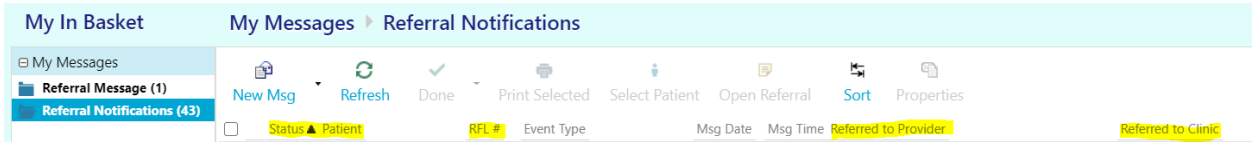
21. In Basket: Notification of completed referrals are only delivered electronically and will appear the In Basket. The In Basket is attached to a Tax ID and ALL notifications for the Tax ID will be found here.

22. Click on Referral Notifications to view In basket messages.



The screenshot shows the "My In Basket" and "My Messages" interface. The "My In Basket" section on the left contains a list of items: "My Messages", "Referral Message (1)", and "Referral Notifications (44)". The "My Messages" section on the right shows a "New Msg" button, a "Refresh" button, and a "Favorite Searches" section with "Private" and "Public" options, both showing "No searches found". At the bottom, there is a "Folder Summary - My Messages" section with a "Referral Message" folder containing 1 / 4 items and a "Referral Notifications" folder containing 44 / 45 items.

23. The In basket can be sorted by any of the column headers within the in basket.



24. The In Basket Authorization can also be sorted and opened by Patient. If the patient is selected, there will be an option at the bottom of the In Basket labeled “Opened Patient”. Click that field and the screen will show authorizations specific for the selected patient.



Examples of Requested Services with Corresponding Questions

Reason for Referral: ECT – Outpatient

| Questions: | Answer |
|--|--|
| 1. Reason for Referral: | ECT - Outpatient |
| ✎ Type of request: | <input type="text"/> |
| ✎ Is this a retrospective request? (Are you requesting coverage for service to begin prior to today?) | <input type="button" value="Yes"/> <input type="button" value="No"/> |
| ✎ What date would you like the authorization to begin? | <input type="text"/> |
| ✎ Diagnosis | <input type="text"/> |
| ✎ Need for ECT | <input type="text"/> |
| | Add |
| ✎ Current medications (list medication name, dosage) | <input type="text"/> |
| ✎ Past medication trials (list medication name, dosage, length of trial, why medication was discontinued) | <input type="text"/> |
| ✎ Patient has undergone medical review and clearance | <input type="button" value="Yes"/> <input type="button" value="No"/> |
| ✎ Recent history and physical, comprehensive metabolic panel, CBC, TSH, EKG, urine pregnancy test (as indicated) are required prior to ECT. Have H&P, appropriate labs been ordered/resulted and in chart or shared with KPWA? | <input type="button" value="Yes"/> <input type="button" value="No"/> |
| ✎ Are you the ECT provider? | <input type="button" value="Yes"/> <input type="button" value="No"/> |
| 2. What is the reason for request? | <input type="text"/> |
| 3. Requested Place of Service? | Office [11] <input type="text"/> |

Reason for Referral: rTMS (Repetitive Transcranial Magnetic Stimulation)

| Questions: | Answer |
|--|----------------------------------|
| 1. Reason for Referral: | rTMS (Repetitive Transcranial) ▾ |
| ✎ Type of request: | ! <input type="text"/> |
| ✎ Is this a retrospective request? (Are you requesting coverage for service to begin prior to today?) | ! Yes No |
| ✎ What date would you like the authorization to begin? | ! <input type="text"/> |
| ✎ Is the patient age 18+ | ! Yes No |
| ✎ Diagnosis | ! <input type="text"/> |
| ✎ Patient does not have any current or past history of psychosis (eg, Major Depressive Disorder with psychotic features; Schizoaffective Disorder, Schizophrenia or other psychotic disorders) | ! <input type="text"/> |
| ✎ Current medications: | ! <input type="text"/> |
| ✎ Past medication trials (list medication name, dosage, length of trial, why medication was discontinued) | ! <input type="text"/> |
| ✎ Patient does not have a cochlear implant, deep brain stimulator, or vagus nerve stimulator | ! <input type="text"/> |
| ✎ Patient does not have epilepsy or history of seizure | ! <input type="text"/> |
| ✎ Patient does not have metallic hardware or implanted magnetic-sensitive medical device (eg, implanted cardioverter-defibrillator, pacemaker, metal aneurysm clips or coils) at a distance within the electromagnetic field of the discharging coil | ! <input type="text"/> |
| ✎ Patient does not have implanted magnetic-sensitive medical device (eg, implanted cardioverter-defibrillator, pacemaker, metal aneurysm clips or coils) at a distance within the electromagnetic field of the discharging | ! <input type="text"/> |
| ✎ Enter current progress monitoring tool used, tool score, date of score during TMS treatment | ! <input type="text"/> |
| ✎ Are you the TMS provider? | ! Yes No |
| 2. What is the reason for request? | ! <input type="text"/> |
| 3. Requested Place of Service? | Office [11] 🔍 |

Reason for Referral: Psychological Testing

| Questions: | Answer |
|---|----------------------------------|
| 1. Reason for Referral: | Psychological Testing |
| ↳ Type of request: | <input type="text"/> |
| ↳ Is this a retrospective request? (Are you requesting coverage for service to begin prior to today?) | Yes No |
| ↳ What date would you like the authorization to begin? | <input type="text"/> |
| ↳ How will the results of testing impact the patient's treatment? | <input type="text"/> |
| ↳ What are the possible diagnoses under consideration? | <input type="text"/> |
| ↳ Has the patient completed previous psychological/neuropsychological testing? | Yes No |
| ↳ Enter additional information you would like to provide. | <input type="text"/> |
| 2. What is the reason for request? | <input type="text"/> |
| 3. Requested Place of Service? | Office [11] <input type="text"/> |

Reason for Referral: MH Medication Management

| Questions: | Answer |
|--|----------------------------------|
| 1. Reason for Referral: | MH Medication Management |
| ↳ Type of request: | <input type="text"/> |
| ↳ Is this a retrospective request? (Are you requesting coverage for service to begin prior to today?) | Yes No |
| ↳ What date would you like the authorization to begin? | <input type="text"/> |
| ↳ If this request can be answered virtually, you can obtain a provider-to-provider consultation with a KP Psychiatrist by calling MindPhone (888-844-4662 8AM-5pm). This number is not intended for patients to call. No referral order is needed. | <input type="text"/> |
| 2. What is the reason for request? | <input type="text"/> |
| 3. Requested Place of Service? | Office [11] <input type="text"/> |

Reason for Referral: MH Intensive Outpatient Evaluation

| Questions: | Answer |
|---|--|
| 1. Reason for Referral: | MH Intensive Outpatient E |
| ↳ Type of request: | <input type="text"/> |
| ↳ Is this a retrospective request? (Are you requesting coverage for service to begin prior to today?) | <input type="button" value="Yes"/> <input type="button" value="No"/> |
| ↳ What date would you like the authorization to begin? | <input type="text"/> |
| ↳ What CPT/Revenue code(s) and quantity are you requesting for treatment? | <input type="text"/> |
| ↳ Number of visits requested? | <input type="text"/> |
| ↳ Is the patient currently experiencing suicidal/homicidal ideation? | <input type="text"/> |
| ↳ Does the patient have an alcohol/substance use problem? | <input type="button" value="Yes"/> <input type="button" value="No"/> |
| ↳ Does the patient have any current social impairments? | <input type="button" value="Yes"/> <input type="button" value="No"/> |
| ↳ Does the patient have any current psychological impairments? | <input type="button" value="Yes"/> <input type="button" value="No"/> |
| ↳ Does the patient have any current physical/health impairments? | <input type="button" value="Yes"/> <input type="button" value="No"/> |
| ↳ Does the patient have any current work/school impairments? | <input type="button" value="Yes"/> <input type="button" value="No"/> |
| ↳ Is the patient taking psychotropic medications? | <input type="button" value="Yes"/> <input type="button" value="No"/> |
| ↳ What is the primary diagnosis being treated? | <input type="text"/> |
| ↳ What symptoms are being treated? | <input type="text"/> Add |
| ↳ Duration of symptoms being treated? | <input type="text"/> |
| ↳ Current symptom severity? | <input type="text"/> |
| ↳ What is the primary therapeutic method utilized for treatment? | <input type="text"/> |
| ↳ What are the goals for treatment? | <input type="text"/> |
| ↳ How is progress measured in treatment? | <input type="text"/> |
| ↳ Current interventions to meet goals. | <input type="text"/> |
| ↳ Current status on patient progress towards goals. | <input type="text"/> |
| ↳ Planned changes in treatment to better meet goals? | <input type="text"/> |
| ↳ Is there a secondary diagnosis being treated? | <input type="button" value="Yes"/> <input type="button" value="No"/> |
| ↳ Select all that apply: | <input type="text"/> Add |
| ↳ Can care be provided at a lower level of care at this time? | <input type="button" value="Yes"/> <input type="button" value="No"/> |
| 2. What is the reason for request? | <input type="text"/> |
| 3. Requested Place of Service? | Office [11] <input type="text"/> |

Reason for Referral: MH Intensive Outpatient Treatment

| Questions: | Answer |
|---|--|
| 1. Reason for Referral: | MH Intensive Outpatient Tr |
| ↳ Type of request: | <input type="text"/> |
| ↳ Is this a retrospective request? (Are you requesting coverage for service to begin prior to today?) | <input type="button" value="Yes"/> <input type="button" value="No"/> |
| ↳ What date would you like the authorization to begin? | <input type="text"/> |
| ↳ What CPT/Revenue code(s) and quantity are you requesting for treatment? | <input type="text"/> |
| ↳ Number of visits requested? | <input type="text"/> |
| ↳ Is the patient currently experiencing suicidal/homicidal ideation? | <input type="text"/> |
| ↳ Does the patient have an alcohol/substance use problem? | <input type="button" value="Yes"/> <input type="button" value="No"/> |
| ↳ Does the patient have any current social impairments? | <input type="button" value="Yes"/> <input type="button" value="No"/> |
| ↳ Does the patient have any current psychological impairments? | <input type="button" value="Yes"/> <input type="button" value="No"/> |
| ↳ Does the patient have any current physical/health impairments? | <input type="button" value="Yes"/> <input type="button" value="No"/> |
| ↳ Does the patient have any current work/school impairments? | <input type="button" value="Yes"/> <input type="button" value="No"/> |
| ↳ Is the patient taking psychotropic medications? | <input type="button" value="Yes"/> <input type="button" value="No"/> |
| ↳ What is the primary diagnosis being treated? | <input type="text"/> |
| ↳ What symptoms are being treated? | <input type="text"/> Add |
| ↳ Duration of symptoms being treated? | <input type="text"/> |
| ↳ Current symptom severity? | <input type="text"/> |
| ↳ What is the primary therapeutic method utilized for treatment? | <input type="text"/> |
| ↳ What are the goals for treatment? | <input type="text"/> |
| ↳ How is progress measured in treatment? | <input type="text"/> |
| ↳ Current interventions to meet goals. | <input type="text"/> |
| ↳ Current status on patient progress towards goals. | <input type="text"/> |
| ↳ Planned changes in treatment to better meet goals? | <input type="text"/> |
| ↳ Is there a secondary diagnosis being treated? | <input type="button" value="Yes"/> <input type="button" value="No"/> |
| ↳ Select all that apply: | <input type="text"/> Add |
| ↳ Can care be provided at a lower level of care at this time? | <input type="button" value="Yes"/> <input type="button" value="No"/> |
| 2. What is the reason for request? | <input type="text"/> |
| 3. Requested Place of Service? | Office [11] <input type="text"/> |

Reason for Referral: MH Outpatient Counseling

| Questions: | Answer |
|---|--|
| 1. Reason for Referral: | MH Outpatient Counseling |
| ↳ Type of request: | <input type="text"/> |
| ↳ Is this a retrospective request? (Are you requesting coverage for service to begin prior to today?) | <input type="button" value="Yes"/> <input type="button" value="No"/> |
| ↳ What date would you like the authorization to begin? | <input type="text"/> |
| 2. What is the reason for request? | <input type="text"/> |
| 3. Requested Place of Service? | Office [11] <input type="text"/> |

Reason for Referral: Eating Disorder Evaluation

| Questions: | Answer |
|---|--|
| 1. Reason for Referral: | Eating Disorder Evaluation |
| ↳ Type of request: | <input type="text"/> |
| ↳ Is this a retrospective request? (Are you requesting coverage for service to begin prior to today?) | <input type="button" value="Yes"/> <input type="button" value="No"/> |
| ↳ What date would you like the authorization to begin? | <input type="text"/> |
| ↳ Is the member currently above or below goal weight? | <input type="button" value="Yes"/> <input type="button" value="No"/> |
| ↳ Number of visits requested? | <input type="text"/> |
| 2. What is the reason for request? | <input type="text"/> |
| 3. Requested Place of Service? | Office [11] <input type="text"/> |

Reason for Referral: Eating Disorder Intensive Outpatient Treatment

| Questions: | Answer |
|---|--|
| 1. Reason for Referral: | Eating Disorder Intensive C <input type="button" value="v"/> |
| ↳ Type of request: | <input type="text"/> |
| ↳ Is this a retrospective request? (Are you requesting coverage for service to begin prior to today?) | <input type="button" value="Yes"/> <input type="button" value="No"/> |
| ↳ What date would you like the authorization to begin? | <input type="text"/> |
| ↳ Number of visits requested? | <input type="text"/> |
| ↳ Is the member currently above or below goal weight? | <input type="button" value="Yes"/> <input type="button" value="No"/> |
| ↳ Starting BMI? | <input type="text"/> |
| ↳ Current BMI? | <input type="text"/> |
| ↳ ADA Ideal weight? | <input type="text"/> |
| ↳ Current weight | <input type="text"/> |
| ↳ Current goal weight? | <input type="text"/> |
| ↳ Weight stable? | <input type="button" value="Yes"/> <input type="button" value="No"/> |
| ↳ Patients calorie intake goal per day? | <input type="text"/> |
| ↳ Actual calorie intake per day? | <input type="text"/> |
| ↳ Is the patient adhering to current dietary plan? | <input type="button" value="Yes"/> <input type="button" value="No"/> |
| ↳ Is patient bingeing? | <input type="button" value="Yes"/> <input type="button" value="No"/> |
| ↳ Is the patient purging? | <input type="button" value="Yes"/> <input type="button" value="No"/> |
| ↳ Is the patient exercising? | <input type="button" value="Yes"/> <input type="button" value="No"/> |
| ↳ Is the patient using laxatives, diuretics? | <input type="button" value="Yes"/> <input type="button" value="No"/> |
| ↳ Is supervision required for bathroom use? | <input type="button" value="Yes"/> <input type="button" value="No"/> |
| ↳ Is the patient currently experiencing suicidal/homicidal ideation? | <input type="text"/> |
| ↳ Is the patient taking psychotropic medications? | <input type="button" value="Yes"/> <input type="button" value="No"/> |
| ↳ What symptoms are being treated? | <input type="text"/> <input type="button" value="Add"/> |
| ↳ Duration of symptoms being treated? | <input type="text"/> |
| ↳ Current symptom severity? | <input type="text"/> |
| 2. What is the reason for request? | <input type="text"/> |
| 3. Requested Place of Service? | Office [11] <input type="button" value="🔍"/> |

Reason for Referral: Esketamine (Spravato)

| Questions: | Answer |
|--|--|
| 1. Reason for Referral: | Esketamine (Spravato) <input type="button" value="v"/> |
| ↳ Type of request: | <input type="text" value=""/> |
| ↳ Is this a retrospective request? (Are you requesting coverage for service to begin prior to today?) | <input type="button" value="Yes"/> <input type="button" value="No"/> |
| ↳ What date would you like the authorization to begin? | <input type="text" value=""/> |
| ↳ Diagnosis | <input type="text" value=""/> <input type="button" value="v"/> |
| ↳ Is patient currently prescribed an antidepressant? | <input type="button" value="Yes"/> <input type="button" value="No"/> |
| ↳ Has the patient inadequately responded to 3 antidepressant medications in at least 3 different classes including: SSRIs, SNRIs, atypical antidepressants, MAOIs and/or TCAs for treatment of MDD | <input type="button" value="Yes"/> <input type="button" value="No"/> |
| ↳ Has the patient inadequately responded to the augmentation therapies listed below? | <input type="text" value=""/> |
| ↳ Lithium augmentation? | <input type="button" value="Yes"/> <input type="button" value="No"/> |
| ↳ First atypical antipsychotic augmentation? | <input type="button" value="Yes"/> <input type="button" value="No"/> |
| ↳ Another atypical antipsychotic or bupropion or mirtazapine or liothyronine or buspirone augmentation? | <input type="button" value="Yes"/> <input type="button" value="No"/> |
| ↳ Has the patient been treated with ECT before? | <input type="button" value="Yes"/> <input type="button" value="No"/> |
| ↳ Has the patient been treated with TMS before? | <input type="button" value="Yes"/> <input type="button" value="No"/> |
| ↳ Provide rationale why TMS is not being considered for treatment | <input type="text" value=""/> |
| ↳ What is the patient's most recent Patient Health Questionnaire-9 (PHQ-9) score? | <input type="text" value=""/> |
| ↳ Does the patient have a history of psychosis? | <input type="button" value="Yes"/> <input type="button" value="No"/> |
| ↳ Does the patient have active substance or alcohol abuse? | <input type="button" value="Yes"/> <input type="button" value="No"/> |
| ↳ Does the patient have active use of cannabinoids, cannabis, or cannabis derivatives? | <input type="button" value="Yes"/> <input type="button" value="No"/> |
| ↳ Does the patient have unstable angina, history of myocardial infarction, or uncontrolled hypertension? | <input type="button" value="Yes"/> <input type="button" value="No"/> |
| ↳ Does the patient have aneurysmal vascular disease, arteriovenous malformation, or history of intracerebral hemorrhage? | <input type="button" value="Yes"/> <input type="button" value="No"/> |
| ↳ Does the patient have increased intracranial pressure nor increased intraocular pressure? | <input type="button" value="Yes"/> <input type="button" value="No"/> |
| ↳ Does the patient have severe hepatic impairment (Child-Pugh Class C) or on renal dialysis? | <input type="button" value="Yes"/> <input type="button" value="No"/> |
| ↳ Is the patient pregnant or breast-feeding? | <input type="button" value="Yes"/> <input type="button" value="No"/> |
| ↳ Does the patient have hypersensitivity to esketamine, ketamine, or any of the excipients? | <input type="button" value="Yes"/> <input type="button" value="No"/> |
| ↳ Are you the esketamine (Spravato) provider? | <input type="button" value="Yes"/> <input type="button" value="No"/> |
| 2. What is the reason for request? | <input type="text" value=""/> |
| 3. Requested Place of Service? | Office [11] <input type="button" value="🔍"/> |