MAO Inhibitors, Inc **NPI:** 1992454094 **Phone:** 323.696.2647 **Fax:** 612.500.4869

Medical Clearance

Completion of this form does not guarantee a prescription from MAO Inhibitors telehealth platform.

Name: _____ **Date of Birth:** _____

Phone Number: _____ **Address:** _____

PRIMARY CARE PROVIDER OR PRIMARY PROVIDER (please complete the rest of this form)

Your patient is completing this form to be evaluated by a provider via telemedicine for treatment of their mental health with a MAO inhibitor. As optimal evaluation and management of some potential side effects may necessitate in-person care, we are asking for your continued care of this patient.

This patient *(check all that apply)*:

- ☐ is under my care and I am monitoring this patient's blood pressure at each visit
- ☐ has a mood disorder (e.g., major depressive disorder, bipolar disorder) and/or anxiety disorder
- ☐ has failed at least 1 other treatment such as a SSRI, SNRI, tricyclic, or atypical antidepressant

Are any of the following contraindications to MAOI treatment applicable to this patient?

- ☐ Yes ☐ No Uncontrolled hypertension (systolic BP >159 and/or diastolic BP>99)
- ☐ Yes ☐ No Hypotension with or without orthostasis
- ☐ Yes ☐ No Personal or family history of pheochromocytoma or porphyria
- ☐ Yes ☐ No Congestive heart failure (CHF)
- ☐ Yes ☐ No History of stroke, transient ischemic attack (TIA), or heart attack
- ☐ Yes ☐ No History of suicidal or homicidal ideation, hallucinations, delusions, or other psychosis
- ☐ Yes ☐ No Dementia, delirium, or substantial cognitive impairment
- ☐ Yes ☐ No Substantial risk for hypoglycemia
- ☐ Yes ☐ No Hepatic impairment or substantial kidney disease (GFR<60)
- ☐ Yes ☐ No Current pregnancy or breast-feeding

Some common side effects are listed below and typically last a few days to a few months:

- Insomnia	- Fatigue	- Headache	- Sexual Dysfunction
- Weight Changes	- Urinary Retention	- Dry Eyes	- High or Low Blood Pressure
- Dry Mouth	- Constipation	- Dizziness or Orthostasis	

Serious effects include **Serotonin Syndrome** and **Tyramine-Induced Hypertension.** The patient will be provided education on medications and foods to avoid and signs and symptoms to observe. Using a single pharmacy for all medications may reduce risk of a contraindicated combination. If you would like a copy of our guide on mao inhibitors which includes a discussion of management strategies for common side effects, please contact us on maoinhibitors.com.

Provider Name: _____ **Signature:** _____

Credentials (e.g., MD/DO, DNP): _____ **Date:** _____

Please return this form to the patient.

MAO Inhibitors, Inc ⬡ **NPI:** 1992454094 ⬡ **Phone:** 323.696.2647 ⬡ **Fax:** 612.500.4869

Release of Prescription Records Authorization

If you have ever taken any of the following medications in the doses **exceeding the amounts listed below**, please complete this form listing the pharmacy that filled that prescription and upload it alongside with the Medical Authorization form when signing up at maoinhibitors.com. We also recommend that you provide your pharmacy with a copy of this form to avoid delays for us needing to access your records. If this does not apply to you, you do not need to complete this form. The doses listed below are the FDA-recommended maximum doses and thus we will need to verify your prescription records. If multiple pharmacies were used for different MAO inhibitors used in excess of the listed doses below, please complete this form as many times as needed.

Patient Name: _____

Date of Birth: _____ **Phone Number:** _____

Address: _____

Check all that apply:

☐ Parnate (Tranylcypromine) - 60 mg per day, **Maximum dose I took**: _____

☐ Emsam patch (transdermal Selegiline) - 12 mg per day, **Maximum dose I took**: _____

☐ Marplan (Isocarboxazid) - 60 mg per day, **Maximum dose I took**: _____

☐ Selegiline (tablets or capsules) - 10 mg per day, **Maximum dose I took**: _____

☐ Nardil (Phenelzine) - 90 mg per day, **Maximum dose I took**: _____

Pharmacy Name: _____

Address: _____

Phone Number: _____ **Fax Number:** _____

Please release my records for the following time period(s) to MAO Inhibitors, Inc:

From _____ to _____

Date (MM/DD/YYYY) Date (MM/DD/YYYY)

- I authorize the above pharmacy to release my entire Patient Prescription Record (PPR) to MAO Inhibitors, Inc including all medications prescribed and dispensed and providers involved in my care for the date(s) listed above.
- I understand that I may revoke this authorization at any time in writing to the above pharmacy address, except to the extent that the pharmacy has acted on this authorization.

Patient Signature: _____ **Date:** _____

***** Pharmacy, Please Fax Prescription Record to 612.500.4869 *****