UPDATE 01.24

Spravato withMe Program Enrollment Form

Spravato® (esketamine) CIII
28 mg nasal spray

Fax completed form to 844-577-7282 | For assistance, call 844-4S-WITHME (844-479-4846)

TO BE COMPLETED BY PROVIDER

Providers can also complete this form online at SpravatoProviderPortal.com

SPRAVATO withMe is unable to process any information without the signed Patient Authorization, included on the Patient section of this form. The information you provide will be used by Johnson & Johnson Health Care Systems Inc., our affiliates, and our service providers for your patient's enrollment and participation in SPRAVATO withMe. Our **Privacy Policy** governs the use of the information you provide. By submitting this form, you indicate that you read, understand, and agree to these terms.

1. Patient Information

Required information in order to process this form.

Patient First Name _____ Patient Last Name _____

Date of Birth (mm/dd/yyyy) _____ Sex: ☐ M ☐ F Patient Phone _____

Patient Address _____

Patient City _____ Patient State _____ Patient ZIP _____

2. Patient Insurance Information

Please either attach a copy of the front and back of insurance card(s) OR complete insurance information below.

Required information in order to process this form. If attaching copy of insurance card(s), information below is not needed.

Primary Medical Insurance (PMI) _____ **PMI Phone** _____

PMI Cardholder First Name _____ PMI Cardholder Last Name _____

PMI Employer _____ PMI Policy # _____ PMI Group # _____

Secondary Medical Insurance (SMI) _____ **SMI Phone** _____

SMI Cardholder First Name _____ SMI Cardholder Last Name _____

SMI Employer _____ SMI Policy # _____ SMI Group # _____

Behavioral Health Insurance (BHI) _____ **BHI Phone** _____

BHI Cardholder First Name _____ BHI Cardholder Last Name _____

BHI Employer _____ BHI Policy # _____ BHI Group # _____

Prescription Drug Insurance (Rx) _____ **Rx Phone** _____

Rx Cardholder First Name _____ Rx Cardholder Last Name _____ Rx Employer _____

Rx BIN # _____ Rx Policy # _____ Rx Group # _____ Rx PCN # _____

Information about your patient's insurance coverage, cost support options, and treatment support is given by service providers for SPRAVATO withMe. The information you get does not require you or your patient to use any Janssen product. Because the information we give you comes from outside sources, SPRAVATO withMe cannot promise the information will be complete. Each healthcare provider and patient is responsible for verifying or confirming any information provided. SPRAVATO withMe cost support is not for patients in the Johnson & Johnson Patient Assistance Foundation.

SPRAVATO withMe is limited to education for patients about SPRAVATO®, its administration, and/or their disease, and is not intended to provide medical advice, replace a treatment plan from the patient's doctor or nurse, or provide case management services.

Please see the full Prescribing Information, including Boxed WARNINGS, and Medication Guide for SPRAVATO®. Provide the Medication Guide to your patients and encourage discussion.

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Patient First Name _____ Patient Last Name _____ DOB _____

3. Prescriber Information

Required information in order to process this form.

Which treatment setting would you like to investigate benefits for?

☐ Prescriber Office ☐ Outpatient Facility

Prescriber First Name _____ Prescriber Last Name _____

Site Name _____

Site Contact First Name _____ Site Contact Last Name _____

Site Address _____

Site City _____ Site State _____ Site ZIP _____

Site Phone _____ Site Fax _____ Prescriber NPI # _____

After Hours Phone _____ Prescriber Email _____ Prescriber Tax ID # _____

4. Clinical Information (This form does NOT serve as a valid prescription. The information requested here is needed to investigate benefits. Benefits will be investigated for both 84 mg and 56 mg dose strengths.)

Common ICD-10 Codes*: ☐ F32.1 ☐ F32.2 ☐ F33.2 ☐ Other ICD-10 Code _____

**These codes do not represent all available codes.*

Treatment History

Concomitant Oral Antidepressant _____

Other therapies prescribed within the current depressive episode (specific to treatment-resistant depression)

_____

Indication

☐ **Treatment-resistant depression in adults**

The patient with MDD and in the current depressive episode has not responded adequately to at least 2 different oral antidepressants of adequate dose and duration.

☐ **Depressive symptoms in adults with major depressive disorder (MDD) with acute suicidal ideation or behavior**

5. Prior Authorization Form Assistance and Status Monitoring

Janssen automatically provides Prior Authorization form assistance, including status updates where required by a patient's health plan, when you enroll your patient into SPRAVATO withMe.

☐ By checking this box, I am requesting to opt out of receiving Prior Authorization form assistance for my patient.

Please see the full Prescribing Information, including Boxed WARNINGS, and Medication Guide for SPRAVATO®. Provide the Medication Guide to your patients and encourage discussion.

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TO BE COMPLETED BY THE PATIENT

Patients can also complete the Program Enrollment Form, including the Janssen Patient Support Program Patient Authorization Form, online. Visit SpravatowithMePatientAuth.com or scan the QR code. Data rates may apply.

SPRAVATO withMe is unable to process any information without the signed Patient Authorization, included in pages 5 and 6 of this form. The information you provide will be used by Johnson & Johnson Health Care Systems Inc., our affiliates, and our service providers for your enrollment and participation in SPRAVATO withMe. Our **Privacy Policy** governs the use of the information you provide. By submitting this form, you indicate that you read, understand, and agree to these terms.

1. Patient Information

Required information in order to process this form.

Patient First Name _____ Patient Last Name _____ Sex: ☐ M ☐ F

Date of Birth (mm/dd/yyyy) _____ Preferred Language if not English: _____

Patient Address _____

Patient City _____ Patient State _____ Patient ZIP _____

Preferred Patient Phone _____ (☐ Cell ☐ Home)

Best Time to Contact: ☐ AM ☐ PM Patient Email _____

Caregiver/Contact _____ Relationship to Patient _____

(A caregiver/contact is someone who can be contacted in place of the patient.)

Caregiver Phone _____ (☐ Cell ☐ Home) Best Time to Contact: ☐ AM ☐ PM Caregiver Email _____

☐ I consent to receive voicemails from the SPRAVATO withMe program that include my medication name and/or disease state.

☐ If I cannot be reached, I authorize SPRAVATO withMe to contact my caregiver.

☐ I prefer and authorize SPRAVATO withMe to contact my caregiver in place of me.

2. Care Navigator Support (optional)

A Care Navigator will be assigned to support you as part of your enrollment with SPRAVATO withMe, unless you opt out by checking the box below.

Care Navigators provide one-to-one educational support throughout your treatment journey, including sharing information about what to expect during treatment, and helping you understand your insurance coverage. Once your enrollment is complete, a Care Navigator will call you from 844-479-4846 ("Janssen" will appear on your caller ID).

Note: Care Navigators do not provide medical advice. Please ask your doctor any questions you might have about your disease and treatment.

☐ **By checking this box, I am requesting to opt out of Care Navigator Support.**

3. Text Message and Marketing Communications Opt-ins (optional)

Text Message Opt-in

You can opt to receive communications from the Care Navigator program via text message. Opting into text messaging allows your Care Navigator to contact you to check your availability to schedule a call or share program updates. We may also send you other messages about the SPRAVATO withMe program.

☐ Yes, I would like to receive text messages from the SPRAVATO withMe program. By selecting this option, I agree to receive text messages at the following cell number.* I understand I am not required to provide my permission to receive text messages to participate in the SPRAVATO withMe program or to receive any other communications I have selected. Cell Phone (required) _____

*Message and data rates may apply. Message frequency varies. Reply STOP to opt out.

Permission for communications outside of Janssen patient support programs

☐ I would like to receive communications relating to my Janssen medication.

☐ I would like to receive communications relating to other Janssen products and services.

For privacy rights and choices specific to California residents, please see Janssen's California privacy notice available at https://www.janssen.com/us/privacy-policy#california

Please read the full Prescribing Information, including Boxed WARNINGS, and Medication Guide for SPRAVATO® and discuss any questions you may have with your healthcare provider.

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Patient First Name _____ Patient Last Name _____ DOB _____

4. SPRAVATO withMe Savings Program and Observation Rebate Program Enrollment (optional)

If you use commercial or private health insurance to pay for your medication:

SPRAVATO withMe Savings Program

Eligible patients pay $10 per treatment for SPRAVATO® medication costs, with an $8,150 maximum program benefit per calendar year. Treatment may include up to three devices administered on the same day. Program limits apply. There is a program benefit limit of list price of the medication and a quantity limit of three devices per day or 23 devices in a 24-day period. There is a quantity limit of 24 devices in a 24-day period for one use per lifetime. Not valid for patients using Medicare, Medicaid, or other government-funded programs to pay for their medication. Terms expire at the end of each calendar year and may change. See full program requirements at **Spravato.com/SavingsRequirements**.

SPRAVATO withMe Observation Rebate Program

Eligible patients pay $0 after rebate to patient for observation of each treatment, with a $500 maximum program benefit per calendar year. Not valid for patients using Medicare, Medicaid, or other government-funded programs to pay for their treatments. Terms expire at the end of each calendar year and may change. Not valid for residents of MA, MI, MN, or RI. There is no income requirement. See full program requirements at **Spravato.com/Observation**.

By attesting to the statements below, I authorize SPRAVATO withMe to check my eligibility for the SPRAVATO withMe Savings Program and the SPRAVATO withMe Observation Rebate Program and enroll me in the Programs, if eligible.

☐ I attest that I have commercial or private health insurance that I will use for my SPRAVATO® medication or treatment costs.*

☐ I attest that I will NOT use any government-funded healthcare program to cover any of my SPRAVATO® medication or treatment costs.†

☐ I attest that I will NOT submit any amounts paid or reimbursed by these programs as a claim for payment to any health plan, patient assistance foundation, Flexible Savings or Health Savings account.

*Examples are commercial insurance from a current/former employer, government employee health insurance, or insurance the patient buys privately or through the Health Insurance Marketplace.

†Examples are Medicare Parts A, B, C (also known as Medicare Advantage Plan), D, and Medicare Supplement, Medicaid, TRICARE, Department of Defense, or Veterans Administration.

You can also enroll online at **MyJanssenCarePath.com/express**.

Information about your insurance coverage, cost support options, and treatment support is given to you by service providers for SPRAVATO withMe. The information you get does not require you to use any Janssen product. The information about whether your treatment is covered by your health plan comes from outside sources, and SPRAVATO withMe cannot guarantee that the information will be complete. It is not a promise of coverage or payment. You are responsible for verifying or confirming any information provided. You should contact your health plan directly for the most current information. You are responsible for meeting your health plan requirements. SPRAVATO withMe cost support is not for patients in the program offered by Johnson & Johnson Patient Assistance Foundation.

SPRAVATO withMe is limited to education about SPRAVATO®, its administration, and/or the condition it treats. It is not intended to provide medical advice, replace a treatment plan you receive from your doctor or nurse, or serve as a reason for you to start or stay on treatment.

Please read the full Prescribing Information, including Boxed WARNINGS, and Medication Guide for SPRAVATO® and discuss any questions you may have with your healthcare provider.

Janssen Patient Support Program
Patient Authorization Form

Patient First Name _____ **Patient Last Name** _____ **DOB** _____

Patients should read the Patient Authorization, sign, and return all pages of the Form to the Janssen Patient Support Program.

- Completed Form may be faxed to 844-577-7282 or mailed to SPRAVATO withMe, 2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560
- Patients may also read, eSign, and submit a digital version of this form at **SpravatowithMePatientAuth.com**

I give permission for each of my "Healthcare Providers" (eg, my physicians, pharmacists, specialty pharmacies, other healthcare providers, and their staff) and "Insurers" (eg, my health insurance plans) to share my Protected Health Information as described on this Form.

My "Protected Health Information" includes any and all information related to my medical condition, treatment, prescriptions, and health insurance coverage.

The following person(s) or class of person(s) are given permission to receive and use my Protected Health Information (collectively "Janssen"):

- Johnson & Johnson Health Care Systems Inc., its affiliated companies, agents, and representatives
- Providers of other sources of funding, including foundations and co-pay assistance providers
- Service providers for the patient support programs, including subcontractors or healthcare providers helping Janssen run the programs
- Service providers maintaining, transmitting, de-identifying, aggregating, or analyzing data from Janssen patient support programs

Also, I give permission to Janssen to receive, use, and share my Protected Health Information in order to:

- see if I qualify for, sign me up for, contact me about, and provide services relating to Janssen patient support programs, including in-home services
- manage the Janssen patient support programs
- give me educational and adherence materials, information, and resources related to my Janssen medication in connection with Janssen patient support programs
- communicate with my Healthcare Providers regarding access to, reimbursement for and fulfillment of my Janssen medication, and to tell my Healthcare Provider that I am participating in Janssen patient support programs
- verify, assist with, and coordinate my coverage for my Janssen medication with my Insurers and Healthcare Providers
- coordinate prescription or treatment location and associated scheduling
- conduct analysis to help Janssen evaluate, create, and improve its products, services, and customer support for patients prescribed Janssen medications
- share and give access to information created by the Janssen patient support programs that may be useful for my care

Janssen Patient Support Program
Patient Authorization Form

I understand that my Protected Health Information may be shared by Janssen for the uses written in this Form to:

- My Insurers
- My Healthcare Providers
- Any of the persons given permission to receive and use my Protected Health Information as mentioned above
- Any individual I give permission as an additional contact

Janssen and the other data recipients listed on this Form may share information about me as permitted on this Form or if any information that specifically identifies me is removed. I understand that Janssen will use reasonable efforts to keep my information private but once my Protected Health Information is disclosed as allowed on this Form, it may no longer be protected by federal privacy laws.

I understand that I am not required to sign this Form. My choice about whether to sign will not change how my Healthcare Providers or Insurers treat me. If I do not sign this Form, or cancel or remove my permission later, I understand I will not be able to participate or receive assistance from Janssen's patient support programs.

I understand that pharmacies that dispense and ship my medication and service providers for the patient support programs may be paid by Janssen for their services and data. This may include payment for sharing Protected Health Information and other data in connection with these programs, as allowed on this Form.

This Form will remain in effect 10 years from the date of signature, except where state law requires a shorter time, or until I am no longer participating in any Janssen patient support programs. Information collected before that date may continue to be used for the purposes set forth in this Form.

I understand that I may cancel the permissions given by this Form at any time by letting Janssen know in writing at: SPRAVATO withMe, 2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560.

I can also cancel my permission by letting my Healthcare Providers and Insurers know in writing that I do not want them to share any information with Janssen.

I further understand that if I cancel my permission it will not affect how Janssen uses and shares my Protected Health Information received by Janssen prior to my cancellation.

I understand I may request a copy of this Form.

Required information in order to process this form.

Patient name (print): _____

Patient sign here: _____ **Date:** _____

If the patient cannot sign, patient's legally authorized representative must sign below:

By: _____ **Print Name:** _____ **Date:** _____

(Signature of person legally authorized to sign for patient)

Describe relationship to patient and authority to make medical decisions for patient:

_____

Janssen
PHARMACEUTICAL COMPANIES OF Johnson & Johnson