UPDATE 06.24

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, and for any optional requests you may select. 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 Johnson & Johnson 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.

The patient support and resources provided by SPRAVATO withMe are not intended to provide medical advice, replace a treatment plan from the patient's doctor or nurse, provide case management services or serve as a reason to prescribe SPRAVATO®.

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 Wanda Prescriber Last Name Lanigan

Site Name Behavioral Health Resiliency PLLC

Site Contact First Name Wanda Site Contact Last Name Lanigan

Site Address 22 Greeley Street 8B

Site City Merrimack Site State NH Site ZIP 03054

Site Phone 603-484-0035 Site Fax 603-825-5620 Prescriber NPI # 1669115853

After Hours Phone 603-484-0035 Prescriber Email wanda@behavioralhealthresiliency.com Prescriber Tax ID # 881010806

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 Opt-Out

Johnson & Johnson 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 Johnson & Johnson 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, and for any optional requests you may select. 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 Opt-In (optional)

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 ("Care Navigator" 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.

☒ **OPT IN: Yes, by checking this box, I am requesting to opt in to Care Navigator Support.**

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

Text Message Opt-In

You can opt in 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.

☐ **OPT IN:** 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 SPRAVATO withMe

☒ **OPT IN:** Yes, I would like to receive communications relating to my SPRAVATO® medication.

☒ **OPT IN:** Yes, I would like to receive communications relating to other Johnson & Johnson products and services.

For privacy rights and choices specific to California, Colorado, Connecticut, Utah, Virginia, and Washington residents, please see J&J's U.S. Supplemental Privacy Notice available at **https://www.janssen.com/us/privacy-policy#supplemental**

Please read 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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4. SPRAVATO withMe Savings Program and Observation Rebate Program Enrollment Opt-In (optional)

SPRAVATO withMe Savings Program

Eligible commercially insured patients pay $10 per treatment for SPRAVATO® medication costs. Treatment may include up to three devices administered on the same day. Maximum program benefit per calendar year and program limits shall 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 commercially insured patients pay $0 after rebate to patient for observation of each treatment. Maximum program benefit per calendar year and program limits shall apply. 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**.

SPRAVATO withMe Savings Program Patient Assignment of Benefits (optional)

☐ By checking this box and signing below, I authorize SPRAVATO withMe to issue payment directly to my provider for any reimbursement amounts attributable to the costs of my SPRAVATO® medication. NOTE: This authorization is not limited to one provider, but grants authorization for all of your treatment providers who submit a rebate request to the SPRAVATO withMe Savings Program. You may, at any time, call SPRAVATO withMe and elect for the Savings Program rebate payments to be sent directly to you instead of your provider.

Patient name (print): _____

Patient sign here: _____ Date: _____

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

☐ Legally Authorized Representative

A person authorized, under state or other applicable laws, to act on behalf of the individual in making healthcare-related decisions such as a parent, legal guardian, or court-appointed representative.

By checking this box, I attest that I have appropriate documentation that appoints me as the patient's legally authorized representative.

By: _____ Print Name: _____ Date: _____

(Signature of person legally authorized to sign for patient)

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 Johnson & Johnson 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.

The support and resources provided by SPRAVATO withMe are 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®. Provide the Medication Guide to your patients and encourage discussion.

Johnson & Johnson

Johnson & Johnson Patient Support Program

Patient Authorization Form

Why should I sign this Form?

This Form gives your Healthcare Providers permission to use and share your medical information with the Johnson & Johnson Patient Support Programs.

Section 1 What health information am I sharing and with whom?

I give permission for my Healthcare Providers and Insurers (eg, my health insurance plans) to share my Protected Health Information, as described on this Form.

My Protected Health Information includes information related to: my medical condition, treatment, prescriptions, and health insurance coverage

My Healthcare Providers may include: physicians, pharmacists, specialty pharmacies, other healthcare providers, and staff members at my healthcare providers' offices

I give permission to these people or groups to receive and use my Protected Health Information (collectively "J&J"):

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

My Protected Health Information may be shared by J&J with these people and groups: my Insurers, my Healthcare Providers, any other people given permission to receive and use my Protected Health Information (as mentioned above), anyone I give permission to as an additional contact, and service providers who review data from J&J patient support programs

J&J and the other groups on this Form may share information about me in two ways: as permitted on this Form, and if any information that identifies me is removed from what has been shared

Section 2 How can giving permission help with patient support programs and access?

I give permission to J&J to receive, use, and share my Protected Health Information to:

- See if I qualify for, sign me up for, contact me about, and provide services relating to J&J patient support programs. This includes in-home services
- Manage the J&J patient support programs
- Give me resources and information related to my J&J medicine in connection with J&J patient support programs. This includes educational and adherence materials
- Communicate with my Healthcare Providers about access, reimbursement, and fulfillment for my J&J medicine
- Inform my Healthcare Provider that I am enrolled in J&J patient support programs
- Help verify and coordinate coverage for J&J medicines with my Insurers and Healthcare Providers
- Help with prescription or treatment location and associated scheduling
- Conduct analysis to help J&J evaluate, create, and improve their patient support services and products for patients prescribed J&J medicines
- Share information from the J&J patient support programs that may be useful for my care

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Section 3 What should I understand before signing this form?

I understand that:

- J&J 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 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 in or receive assistance from J&J's patient support programs
- The following groups may be paid by J&J for their services and data, including Protected Health Information:
  - Pharmacies that dispense and ship my medicine
  - Service providers for the J&J patient support programs
- This Form will remain in effect 10 years from the date I signed below, except if:
  - State law requires a shorter time or
  - I am no longer in any J&J patient support program
- Information collected before that date may continue to be used for the purposes noted in this Form
  - I may cancel the permissions given by this Form at any time by letting J&J 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 J&J
  - If I cancel my permission, it will not affect how J&J uses and shares my Protected Health Information received by J&J before my cancellation
  - I may request a copy of this Form

Section 4 Fill in Personal Information & Sign Patient Authorization Form

Patient name (print): _____

Email Address: _____

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

If 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:

_____

Sign and return this form to:

Fax to: 844-577-7282

SPRAVATO withMe
2250 Perimeter Park Drive, Suite 300
Morrisville, NC 27560

Or, eSign a digital Form:

In your healthcare provider's office

At **SpravatowithMePatientAuth.com** or scan the QR code

Data rates may apply.