

Janssen CarePath cannot accept any information without a Patient Authorization Form, which can be found at JanssenCarePath.com or as the last 2 pages of this document. The information you provide will be used by Janssen Pharmaceuticals, Inc., our affiliates, and our service providers for your patient's enrollment and participation in Janssen CarePath. 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. Provider Information (Required)

I am the Referring Physician

I am the Prescribing & Treating Physician. If Prescribing & Treating Physician, how do you plan to bill? (optional) CMS-1500 UB-04 Unsure

Provider Name (First, Last) _____ Specialty (optional) _____

Site Name _____ Site Contact _____

Address _____ City _____ State _____ ZIP _____

Email _____

Phone _____ Fax _____ Emergency After Hours Phone _____

Provider NPI # _____ DEA # _____ State License # _____ Tax ID # _____

I agree that my contact information may be shared with another healthcare professional, when requested, to assist with patient care.

2. Product Acquisition Plan

Healthcare Setting or Pharmacy must be Risk Evaluation and Mitigation Strategy (REMS)-certified prior to ordering and/or dispensing SPRAVATO[®]. Information will be provided based on the patient's health plan requirements (major medical and/or prescription).

Please select one of the following checkboxes for your preferred product acquisition:

REMS-certified Pharmacy (Retail or Specialty Pharmacy): We will provide information associated with REMS-certified pharmacies that are covered under this patient's plan. Medical Buy & Bill

Undecided

Complete the section below if your patient has a preferred retail or specialty pharmacy.

Pharmacy Name _____

Address _____ City _____ State _____ ZIP _____

3. Clinical Information (Required) The information requested here is needed to investigate benefits. This form does NOT serve as a valid prescription.

Common ICD-10 Codes*: F32.1 F32.2 F32.3 R45.851 Other ICD-10 Code _____

*These codes do not represent all available codes.

Treatment Information for SPRAVATO[®]

Dose Strength(s) to Investigate: 84 mg 56 mg Both **Concomitant Oral Antidepressant:** _____

Indication: Depressive symptoms in adults with Major Depressive Disorder (MDD) with acute suicidal ideation or behavior (MDSI)
 Adults with treatment-resistant depression (TRD)

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

Treatment History: Therapies previously prescribed within the current depressive episode.

The information requested above is for benefits investigation purposes only. This form does not constitute a valid prescription.

Information about your patient's insurance coverage, cost support options, and treatment support is given by service providers for Janssen CarePath. 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, Janssen CarePath cannot promise the information will be complete. Janssen CarePath is not for patients in the Johnson & Johnson Patient Assistance Foundation.

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

4. Treatment Location

If your patient has selected a treatment location, please complete the Location Information below. To request Treatment Location Support for your patient, please check the box at the bottom of this section.

Check here if treatment location information is the same as the Provider Information above.

Location Information

Prescriber Name (First, Last) _____ Specialty (optional) _____

Practice Name _____ NPI # (if known) _____

Address _____ City _____ State _____ ZIP _____

Phone _____ Fax _____

Treatment Location Support

Janssen CarePath can help identify an appropriate treatment location for your patient if one has not been listed above.

Provide information and assistance to help my patient select a treatment location.

5. Patient Information (Required)

Name (First, MI, Last) _____ Sex: M F

Date of Birth (mm/dd/yyyy) _____ Preferred Language: English Spanish Other _____

Address _____

City _____ State _____ ZIP _____

Primary Phone _____ Secondary Phone (optional) _____ Best Time to Contact _____

Email _____

Caregiver/Contact _____ Relationship to Patient _____
(A caregiver/contact is someone who can be contacted in place of the patient.)

Primary Phone _____ Secondary Phone (optional) _____ Best Time to Contact _____

Email _____

- I authorize Janssen CarePath to leave a message, including the name of the Janssen medication indicated on this form, if I am unavailable when they call.
- If I cannot be reached, I authorize Janssen CarePath to contact my caregiver.
- I prefer and authorize Janssen CarePath to contact my caregiver in place of me.

6. Insurance Information (Required) Please provide insurance information relevant to the coverage request.

Please do not investigate out-of-network benefits.



Please attach copy of the front and back of insurance cards OR complete all required information below.

Prescription Drug Insurance _____ Phone _____

Cardholder Name (First, MI, Last) _____ Policy # _____ Group # _____

Primary Medical Insurance _____ Phone _____

Cardholder Name (First, MI, Last) _____ Policy # _____ Group # _____

Secondary Medical Insurance _____ Phone _____

Cardholder Name (First, MI, Last) _____ Policy # _____ Group # _____

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

7. Prior Authorization (Automatically provided with benefits investigation requests from Prescribing & Treating Physicians. You may opt out by checking the box below. Referring Physicians are automatically opted out.)

Prior Authorization Form Assistance and Status Monitoring

Janssen CarePath assists your office in providing the requirements of the patient's health plan related to prior authorization for treatment with SPRAVATO[®]. Assistance includes obtaining the health plan-specific prior authorization form, and providing it to your office for completion and submission in the office's sole discretion. Janssen CarePath also actively monitors the status of prior authorization submission to the patient's plan and provides status updates to your office with respect to this patient's prior authorization for treatment with SPRAVATO[®].

I do **NOT** wish to receive Prior Authorization Form Assistance or Status Monitoring.

8. Janssen CarePath Savings Program (Optional)

Eligible patients using commercial insurance can save on out-of-pocket Janssen medication costs. Patients must be enrolled in the Savings Program before receiving their Janssen medication in order to qualify for out-of-pocket cost savings. See full program requirements at [Spravato.JanssenCarePathSavings.com](https://www.spravato.janssencarepathsavings.com) or call Janssen CarePath at 877-CarePath (877-227-3728).

I would like Janssen CarePath to check the patient's eligibility for and enroll the patient in the Janssen CarePath Savings Program if the results of this benefits investigation determine that the patient has commercial or private health insurance.

Eligibility Questions

1. Will the patient use commercial or private health insurance for their Janssen medication? 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.

Yes, the patient has commercial or private health insurance that they will use for their Janssen medication

No, the patient does not have commercial or private health insurance that they will use for their Janssen medication

2. Do you confirm the patient will NOT ask any government-funded healthcare program to cover any Janssen medication costs? (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.)

Yes, I confirm the patient will NOT seek payment from any government-funded healthcare program for their Janssen medication

No, the patient may seek payment from a government-funded healthcare program for their Janssen medication

3. Do you confirm the patient will NOT submit any costs paid by this program as a claim for payment to any health plan, patient assistance foundation, flexible spending account, or healthcare savings account?

Yes, I confirm that the patient will NOT submit out-of-pocket costs paid by this program as a claim

No, the patient may submit out-of-pocket costs paid by this program as a claim

Please see full [Prescribing Information](#), including **Boxed WARNINGS**, and [Medication Guide](#) for SPRAVATO[®]. Provide the Medication Guide to your patients and encourage discussion.

Janssen Patient Support Program

Patient Authorization Form

Patients should read the Patient Authorization, check the desired permission boxes, and return both pages of the Form to the Janssen Patient Support Program.

- Download a copy, print, check the desired boxes, and sign. Your healthcare provider may scan the completed Form and upload on Provider Portal, or completed Form may be faxed to 833-777-7282 or mailed to Janssen CarePath, PO Box 13135, La Jolla, CA 92037.
- You may be able to eSign a digital Form in your healthcare provider's office or on the Janssen CarePath Patient Account at [MyJanssenCarePath.com](https://www.mylanssencarepath.com)

Patient Name _____ **Email Address** _____

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

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 Patient Support Program Patient Authorization Form

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 my Healthcare Providers may be paid by Janssen for sharing my Protected Health Information with Janssen 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: Janssen CarePath, PO Box 13135, La Jolla, CA 92037.

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.

Permission for communications outside of Janssen patient support programs:

- Yes, I would like to receive communications relating to my Janssen medication.
- Yes, 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>

Permission for text communications:

- Yes, I would like to receive text messages. By selecting this option, I agree to receive text messages as allowed by this Form to the cell phone number provided below. Message and data rates may apply. Message frequency varies. I understand I am not required to provide my permission to receive text messages to participate in the Janssen patient support programs or to receive any other communications I have selected.

Cell phone number: _____

Patient name (print): _____

Patient sign here: _____ Date: _____

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

By: _____ Date: _____

(Signature of person legally authorized to sign for patient)

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