UPDATE 09.22

Spravato withMe

Spravato® (esketamine) CIII 28 mg nasal spray

# Prescription Enrollment Form

Complete and fax this form to SPRAVATO withMe at 844-577-7282.

SPRAVATO withMe is unable to process any information without the signed Patient Authorization Form, included on the last 2 pages of this form. The Patient Authorization Form is also available upon request by calling 844-4S-WITHME (844-479-4846). 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 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.

All fields are REQUIRED except where noted

## 1. Patient Information

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

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

Address _____ City _____ State _____ ZIP _____

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

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

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

☐ I authorize SPRAVATO withMe to leave a message, including the name of the medication indicated on this form, if I am unavailable when they call.

☐ 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. Insurance Information (Please attach copy of the front and back of insurance cards OR complete below.)

**Prescription Drug Insurance** _____ Phone _____ Employer _____

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

**Primary Medical Insurance** _____ Phone _____ Employer _____

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

**Secondary Medical Insurance/Behavioral Health Insurance** _____ Phone _____

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

## 3. Prescriber Information

Where do you plan for the patient to be treated?

☐ Physician's Office (CMS-1500) ☐ Outpatient Facility (UB-04) ☐ Undecided

Treating Physician Name (First, Last) _____ Specialty (optional) _____

Treatment Site Name _____ Treatment Site Contact _____

Address _____ City _____ State _____ ZIP _____

Phone _____ Fax _____ After Hours Phone _____ Email _____

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.

If referring physician is known: Name (First, Last) _____ Phone _____ Fax _____

## 4. Product Acquisition Plan (Optional)

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: We will provide information associated with REMS-certified pharmacies that are covered under this patient's plan.

☐ Medical Buy & Bill

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

Spravato withMe

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Patient First Name _____ Patient Last Name _____ DOB _____

## 5. Prescription Information

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 History:**

Concomitant Oral Antidepressant _____ Other therapies prescribed within the current depressive episode _____

### SPRAVATO® Pharmacy Prescription

Administer SPRAVATO® in conjunction with an oral antidepressant (AD).

### ☐ Treatment-resistant depression in adults

☐ 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.

**Induction Phase: Weeks 1 to 4†**

**Day 1 Starting dose:** Dispense one 56 mg Dose Kit (two 28 mg nasal spray devices)

**Subsequent doses:** Dispense ☐56 mg Dose Kit (two 28 mg nasal spray devices) OR ☐84 mg Dose Kit (three 28 mg nasal spray devices) administered twice per week; Quantity _____ Refills _____

†Evidence of therapeutic benefit should be evaluated at the end of the induction phase to determine need for continued treatment.

**Maintenance Phase: Weeks 5 to 8**

**Weeks 5 to 8:** Dispense ☐56 mg Dose Kit (two 28 mg nasal spray devices) OR ☐84 mg Dose Kit (three 28 mg nasal spray devices) administered once weekly; Quantity _____ Refills _____

**Week 9 and after:** Dispense ☐56 mg Dose Kit (two 28 mg nasal spray devices) OR ☐84 mg Dose Kit (three 28 mg nasal spray devices) administered ☐every 2 weeks OR ☐once weekly‡; Quantity _____ Refills _____

‡Dosing frequency should be individualized to the least frequent dosing to maintain remission/response.

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

Dispense ☐84 mg Dose Kit (three 28 mg nasal spray devices) administered twice per week for 4 weeks§; Quantity _____ Refills _____

OR ☐56 mg Dose Kit (two 28 mg nasal spray devices) administered twice per week for 4 weeks§‖; Quantity _____ Refills _____

§After 4 weeks of treatment, evidence of therapeutic benefit should be evaluated to determine need for continued treatment. Use beyond 4 weeks has not been evaluated in the treatment of depressive symptoms in patients with MDD with acute suicidal ideation or behavior.

‖Dosage may be reduced to 56 mg twice per week based on tolerability.

**Treatment Location Ship to:**

Site Name _____ Site Contact _____ Phone _____

Address _____ City _____ State _____ ZIP _____

PRESCRIBER SIGNATURE (NO STAMPS ALLOWED) REQUIRED TO VALIDATE PRESCRIPTION: I certify that therapy with SPRAVATO® is medically necessary for this patient. I will be supervising the patient's treatment accordingly, and I have reviewed the current SPRAVATO® full Prescribing Information. I authorize SPRAVATO withMe to act on my behalf for the limited purposes of transmitting the above prescription(s) to the appropriate pharmacy(ies) designated by me, the patient, or the patient's plan.

**PRESCRIBER SIGNATURE** _____ **PRESCRIBER SIGNATURE** _____ Date _____

Dispense as Written Substitution Allowed

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. 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 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. Completed Form may be faxed to 844-577-7282 or mailed to Partner withMe, 680 Century Point, Lake Mary, FL 32746.
- You may be able to eSign a digital Form

**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 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

# Janssen Patient Support Program
# Patient Authorization Form

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: Partner withMe, 680 Century Point, Lake Mary, FL 32746.

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:** _____ **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