Janssen CarePath

Spravato® (esketamine) nasal spray

Initiating benefits investigation is easy

For providers

1. Complete the required Provider Information on page 1
2. If Prior Authorization assistance is NOT needed, check the appropriate box in the Prior Authorization section on page 1 to opt out
3. Complete the required Clinical Information and Treatment Location sections on page 2

Please note: In order to provide Prior Authorization assistance, all required fields are needed.

For your patients/caregivers

1. Have your patient complete the Patient Information and Insurance Information sections on page 3
2. Have your patient complete the Janssen CarePath Savings Program section on page 4 to determine eligibility
3. Have your patient read, sign, and date the Patient Authorization on pages 5 and 6
   - Give your patient a copy of the signed HIPAA Patient Authorization Form and keep the original for your records

Fax all pages of the completed and signed Benefits Investigation Form to Janssen CarePath at 833-777-7282

Here's what happens next

For providers

Janssen CarePath will:

- Verify medical and pharmacy benefits within 2 business days and confirm receipt of requests same day
- Provide you with a verification of benefits

For your patients/caregivers

Janssen CarePath will:

- Contact your patient to let them know about resources available to help them start and stay on therapy
- Provide your patient with a summary verification of benefits letter and inform them about cost support options
- Provide information and assistance to help your patient select a treatment location, if requested
- Enroll your eligible patient with commercial or private health insurance in the Janssen CarePath Savings Program, if requested by your patient with benefits investigation completion

Need help? Call **844-777-2828**
Monday–Friday, 8:00 AM–8:00 PM ET

Fax
833-777-7282

Visit us online
JanssenCarePath.com/hcp/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.

Janssen CarePath UPDATE 12.19

Benefits Investigation Form

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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? ■ CMS-1500 ☐ UB-04 ☐ Unsure

Provider Name (First, Last) Rachel Dalthorp, MD Specialty (optional) Psychiatrist

Site Name Balance Women's Health Site Contact Kaitlyn Filipski

Address 1109 SW 30th Ct Suite B

City Moore State OK ZIP 73160

Email kaitlyn@balancewomenshealth.com

Phone (405) 703-0937 Fax (405) 676-5802

Emergency After Hours Phone (405) 703-0937

NPI # 1811218803 DEA # FD8760969 State License # OK27766 Tax ID # 46-5221779

(Please provide the NPI # associated with the billing method.)

Site Type: ☐ Inpatient ☐ Hospital Outpatient ☐ Outpatient Clinic ■ Private Practice ☐ Other _____

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

2. 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. ☐

By providing your information and information about your patient on the Benefits Investigation Form, you are requesting the services described on this form. The information you provide will only be used by Johnson & Johnson Health Care Systems Inc., our affiliates, and our service providers involved in delivering these services. You may withdraw your request for these services by calling 844-777-2828. Our Privacy Policy governs the use of the information you provide. By providing the information and submitting this form, you indicate you read, understand, and agree to these terms.

Patient insurance benefits investigation and other Janssen CarePath program offerings are provided by third-party service providers for Janssen CarePath, under contract with Johnson & Johnson Health Care Systems Inc. on behalf of Janssen Pharmaceuticals, Inc. (Janssen). Janssen CarePath is not available to patients participating in the Patient Assistance Program offered by Johnson & Johnson Patient Assistance Foundation. The availability of information and assistance may vary based on the Janssen medication, geography and other program differences. Janssen CarePath assists healthcare providers (HCPs) in the determination of whether treatment could be covered by the applicable third-party payer based on coverage guidelines provided by the payer, and patient information provided by the HCP under appropriate authorization following the provider's exclusive determination of medical necessity. This information and assistance are made available as a convenience to patients, and there is no requirement that patients or HCPs use any Janssen product in exchange for this information or assistance. Janssen assumes no responsibility for and does not guarantee the quality, scope, or availability of the information and assistance provided. The third-party service providers, not Janssen, are responsible for the information and assistance provided under this program. Each HCP and patient is responsible for verifying or confirming any information provided. All claims and other submissions to payers should be in compliance with all applicable requirements.

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

Diagnosis/ICD Code F33.9 Approximate date of patient's diagnosis (mm/dd/yyyy) _____

Treatment Information for SPRAVATO®

Dose Strengths to Investigate: ☐ 84 mg ☐ 56 mg ■ Both **Concomitant Oral Antidepressant:** _____

■ **The patient with Major Depressive Disorder (MDD) and in the current depressive episode has not responded adequately to at least two different antidepressants of adequate dose and duration.**

Treatment History: Select therapies previously prescribed within the current depressive episode.

☐ Celexa® (citalopram) ☐ Pexeva® (paroxetine mesylate) ☐ Cymbalta® (duloxetine) ☐ Fetzima® (levomilnacipran)
☐ Lexapro® (escitalopram) ☐ Prozac® (fluoxetine) ☐ Effexor® (venlafaxine) ☐ Khedezla® (desvenlafaxine succinate)
☐ Paxil® (paroxetine) ☐ Zoloft® (sertraline) ☐ Effexor XR® (venlafaxine XR) ☐ Pristiq® (desvenlafaxine)

☐ Other: _____

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

4. Product Acquisition Plan

Healthcare Setting or Pharmacy must be Risk Evaluation and Mitigation Strategy (REMS) certified prior to ordering and/or dispensing SPRAVATO®.

☐ Medical Buy & Bill ■ Undecided

☐ REMS-certified Pharmacy Name _____

Address _____ Address 2 _____

City _____ State _____ ZIP _____

5. 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 on page 1.

Location Information

☐ Inpatient ☐ Hospital Outpatient ☐ Outpatient Clinic ☐ Private Practice ☐ Other _____

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

Practice Name _____

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.

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6. 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.

7. Insurance Information (Required) Please provide insurance information for all health insurance coverage your patient may have.

☐ **Please see attached front and back copy of insurance card(s).**

***Optional information**

Primary Medical Insurance

Primary Insurance Carrier _____ Phone _____

Cardholder Name (First, MI, Last) _____

*Relationship to Cardholder _____ Policy # _____ Group # _____

Secondary Medical Insurance

Secondary Insurance Carrier _____ Phone _____

Cardholder Name (First, MI, Last) _____

*Relationship to Cardholder _____ Policy # _____ Group # _____

Prescription Drug Insurance

Prescription Drug Insurer _____ Card BIN # _____ Phone _____

Cardholder Name (First, MI, Last) _____

*Relationship to Cardholder _____ Policy # _____ Group # _____

☐ **Please do not investigate out-of-network benefits.**

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8. Janssen CarePath Savings Program (Optional)

Eligible patients using commercial insurance can save on out-of-pocket Janssen medication costs. See program requirements at Spravato.JanssenCarePathSavings.com.

■ I would like Janssen CarePath to check my eligibility for and enroll me into the Janssen CarePath Savings Program if the results of this benefits investigation determine I have commercial or private health insurance that covers a portion of my medication costs.

Who should receive your Savings Program rebate payment?

■ **Send Funds to Provider** (By selecting this option, you must share your Savings Program card information with your provider.)

By selecting this option, you understand and authorize that your Janssen CarePath Savings Program out-of-pocket payment will be sent to the provider who submits the claim on your behalf for payment of your out-of-pocket Janssen medication costs. If your doctor's office does not accept your Savings Program card information, you can always submit a rebate form and proof of medication payment to receive your rebate. You may, at any time, call Janssen CarePath to change your selection.

☐ **Mail Rebate Check to Patient** (By selecting this option, you must submit a rebate form, including proof of payment, to receive a rebate check by mail.)

For each Savings Program request, you will need to submit a rebate form, including proof of payment. If you used medical insurance to pay for your medication, you will also need to submit an Explanation of Benefits (EOB). For each request you submit, we will mail you your out-of-pocket payment via check with a letter notifying you that your request was successfully processed. You will be responsible for upfront payment at time of treatment.

If you use your pharmacy/prescription insurance to pay for your medication, you will receive instant savings, regardless of your selection above. If your pharmacy can't process your Janssen CarePath Savings Program card, you can submit a rebate form and proof of medication payment to receive your rebate.

Eligibility Questions

1. Do you currently have commercial or private health insurance that you will use for your Janssen medication, including commercial insurance provided through an employer or former employer, provided to you as a federal or state employee, and insurance you pay for yourself, as well as plans available through state and federal healthcare exchanges?

☐ **Yes,** I have commercial or private health insurance that I will use for my Janssen medication

☐ **No,** I do not have commercial or private health insurance that I will use for my Janssen medication

2. Do you confirm that you will NOT seek reimbursement from any state or federal government-subsidized healthcare program to cover a portion of the Janssen medication costs such as 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 that I will NOT seek reimbursement from any state or federal government-subsidized program for my Janssen medication

☐ **No,** I may seek reimbursement from a state or federal government-subsidized healthcare program for my Janssen medication

3. Do you confirm that you will not submit out-of-pocket costs paid by this program as a claim for payment to any third-party payer, pharmaceutical patient assistance foundation, or account such as a Flexible Spending Account (FSA), a Health Savings Account (HSA), or a Health Reimbursement Account (HRA)?

☐ **Yes,** I confirm that I will NOT submit out-of-pocket costs paid by this program as a claim for payment to any third-party payer, pharmaceutical patient assistance foundation, or account

☐ **No,** I may submit out-of-pocket costs paid by this program as a claim for payment to a third-party payer, pharmaceutical patient assistance foundation, or account

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

Janssen CarePath

HIPAA Patient Authorization for Janssen CarePath

The below authorization is in connection with Janssen CarePath programs my doctor has discussed with me and I have agreed to be enrolled in.

I hereby authorize the use and/or disclosure of my private health information, described below, which includes "Protected Health Information" as defined in federal laws called the Privacy Regulations developed under the Health Insurance Portability and Accountability Act of 1996 (as amended, "HIPAA"). In general terms, I understand that Protected Health Information is health information that identifies me or that could be used to identify me. I understand that this authorization is voluntary. Our **Privacy Policy** governs the use of the information you provide.

The following person(s) or class of persons are authorized to share my information:

1. Physicians, pharmacists, other healthcare providers or support staff who have provided or will provide treatment or services to me (referred to as "My Healthcare Providers")
2. The approved third-party service providers administering and supporting Janssen CarePath offerings, under contract with Janssen Pharmaceuticals, Inc. These service providers are authorized to manage, administer, and/or support Janssen CarePath programs, including but not limited to **MySpravatoConsent.com** (referred to as "Janssen CarePath")
3. My health plan or other third-party payer (referred to as "My Payer")

The following person(s) or class of persons are authorized to receive and use my information:

1. My Healthcare Providers
2. Janssen CarePath
3. My Payer

Description of the information that may be used and/or shared:

My "Personal Health Information," which includes my diagnosis, prescribed therapy, insurance information, name, address, phone number, and a description of the resources I have requested or received from Janssen CarePath. For prescribed therapies, I understand that the information disclosed about me may include mental health information and/or records.

The information will be used and/or shared for the following purpose(s) as applicable:

1. Enroll me in, determine my eligibility for, and contact me about Janssen medication support programs
2. Send me requested educational materials, information, and resources related to the Janssen CarePath program or my Janssen medication
3. Verify, investigate, assist with, and coordinate my coverage for my Janssen medication with My Payer
4. Identify treatment location and/or provide information and assistance to help my transition to my next treatment location
5. Share with my Healthcare Provider(s) information generated by Janssen CarePath that may be useful for my care
6. In response to a court order, subpoena, or otherwise required by law

I also authorize Janssen CarePath to de-identify and use my health information to improve, develop and evaluate Janssen CarePath, its offerings and materials, and to evaluate patient access to and adherence to my Janssen medication.

Janssen

Janssen CarePath

I understand that my Protected Health Information will not be used or disclosed by Janssen CarePath for any other purpose without my prior authorization unless permitted by law or unless information that specifically identifies me is removed. I understand that Janssen CarePath will make every effort to keep my information private. I understand that if my information is accidentally shared, federal privacy laws do not require that the person/party receiving it will not disclose the information further and that such information provided to a third party may no longer be protected by federal privacy laws.

I understand that I am not required to sign this HIPAA Patient Authorization Form. My choice about whether to sign will not change the way my Healthcare Providers or Payer treat me. If I refuse to sign the HIPAA Patient Authorization Form, or cancel or revoke my authorization later, I understand that this means I will not be able to participate or receive assistance from Janssen CarePath.

1. I understand that I am entitled to a signed copy of this authorization.
2. I understand that this authorization shall expire either when I stop receiving Janssen CarePath resources or 10 years from the date of this authorization, whichever occurs first.
3. I understand that I may cancel or revoke this authorization at any time by notifying Janssen CarePath in writing at Janssen CarePath, P.O. Box 13135, La Jolla, CA 92037. I understand this will not affect information used and disclosed prior to receipt of my cancellation or revocation.
4. I understand that I have the right to review my health information that has been disclosed upon written request to Janssen CarePath, P.O. Box 13135, La Jolla, CA 92037.

Redisclosure: I understand that my Protected Health Information may be redisclosed by Janssen CarePath, for the purposes outlined above—to my health plan(s) or other third-party payer(s), my healthcare providers, and any individual I designate as a caregiver—and I specifically authorize such redisclosures.

☐ I would like to receive information and updates about SPRAVATO® (esketamine) Nasal Spray CIII.

Patient name _____ Date of birth (mm/dd/yyyy) _____

Patient address _____

City _____ State _____ ZIP _____

Patient email _____

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:

_____

Please call Janssen CarePath at 844-777-2828 or follow up with your doctor if you have questions about Janssen CarePath or this authorization.

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

Janssen