Janssen CarePath

Spravato® (esketamine) CIII 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 Janssen Patient Support Program 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
- 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 **877-CarePath** (877-227-3728)
Monday–Friday, 8:00 AM–8:00 PM ET
Multilingual phone support available

Fax
833-777-7282

Visit us online
JanssenCarePath.com/HCP/Spravato

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

Janssen CarePath UPDATE 1.21

Benefits Investigation Form

Complete and fax this form to Janssen CarePath at 833-777-7282.

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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 877-CarePath (877-227-3728). Our Privacy Policy further 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.

1. Provider Information (Required)

☐ I am the Referring Physician

***Optional information**

☐ 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) _____ Specialty (optional) _____

Site Name _____ Site Contact _____

Address _____

City _____ State _____ ZIP _____

Email _____

Phone _____ Fax _____

Emergency After Hours Phone _____

Provider NPI # _____ DEA # _____

State License # _____ Tax ID # _____

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.

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 _____ 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®. Information will be provided based on the patient's health plan requirements.

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

☐ REMS-certified Retail Pharmacy (If checked, please complete section below.)
☐ Specialty Pharmacy Support (We will provide information associated with REMS-certified Specialty Pharmacies that are covered under this patient's plan.)
☐ Medical Buy & Bill
☐ Undecided

Complete this section if you have checked REMS-certified Retail Pharmacy or if your patient has a preferred Specialty Pharmacy.

Pharmacy Name _____

Address _____ 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 _____ 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.

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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.**

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

8. Janssen CarePath Savings Program (Optional)

Eligible patients using commercial insurance can save on out-of-pocket Janssen medication costs. You must be enrolled in the Savings Program before receiving your Janssen medication in order to qualify for out-of-pocket cost savings. See full program requirements at Spravato.JanssenCarePathSavings.com.

☐ I would like Janssen CarePath to check my eligibility for and enroll me in 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.

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-funded 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-funded program for my Janssen medication

☐ **No,** I may seek reimbursement from a state or federal government-funded 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

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Janssen Patient Support Program
Patient Authorization Form

- **Patients should read the Patient Authorization, check the desired permission boxes, and return the form to 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**

Patient Name _____ **Email** _____

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.

My "Protected Health Information" includes but is not limited to the following 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 include foundations and co-pay assistance providers
- Service providers supporting or analyzing data from Janssen patient support programs

Specifically, 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, and contact me about Janssen patient support programs
- 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 confirm to my Healthcare Provider that support has been provided by the 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

I understand that my Protected Health Information will not be used or shared by Janssen for any other use without my permission. Janssen may share information about me where legally allowed or if any information that specifically identifies me is removed. I understand that Janssen will make every effort to keep my information private. Further, I understand that if my information is accidentally shared, federal privacy laws do not require that the person/party receiving it not share 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 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.

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 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:

_____

janssen