

## Spravato withMe Program Enrollment Form



Fax completed form to 844-577-7282 | For assistance, call 844-4S-WITHME (844-479-4846)

### TO BE COMPLETED BY THE PATIENT



Data rates may apply.

Patients can also complete the Program Enrollment Form, including the Johnson & Johnson Patient Support Program Patient Authorization Form, online. Visit [SPRAVATOWithMePatientAuth.com](https://SPRAVATOWithMePatientAuth.com) or scan the QR code.

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 SPRAYATO 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 SPRAYATO withMe program that include my medication name and/or disease state.
- ☐ If I cannot be reached, I authorize SPRAYATO withMe to contact my caregiver.
- ☐ I prefer and authorize SPRAYATO 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 SPRAYATO withMe program.

☐ **OPT IN:** Yes, I would like to receive text messages from the SPRAYATO 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 SPRAYATO 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 SPRAYATO withMe

☐ **OPT IN:** Yes, I would like to receive communications relating to my SPRAYATO® 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 [InnovativeMedicine.JNJ.com/us/privacy-policy#supplemental](https://InnovativeMedicine.JNJ.com/us/privacy-policy#supplemental)

Please read full [Prescribing Information](#), including Boxed WARNINGS, and [Medication Guide](#) for SPRAYATO® and discuss any questions you may have with your healthcare provider.



Fax completed form to 844-577-7282 | For assistance, call 844-4S-WITHME (844-479-4846)

Patient First Name \_\_\_\_\_

Patient Last Name \_\_\_\_\_

DOB \_\_\_\_\_

## 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. Maximum program benefit per calendar year and program limits shall apply. Treatment may include up to three devices administered on the same day. Depending on your health insurance plan, savings may apply toward co-pay, co-insurance, or deductible. 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. Terms expire at the end of each calendar year. Offer subject to change or end without notice. Restrictions, including monthly maximums, may apply. Program does not cover the cost of treatment observation. Participate without sharing your income information. See full program requirements at [Spravato.com/SavingsRequirements](https://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 shall apply. Offer subject to change or end without notice. Not valid for residents of MA, MI, MN, or RI. Participate without sharing your income information. See full program requirements at [Spravato.com/Observation](https://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 [Account.JNJwithMe.com](https://Account.JNJwithMe.com)

### 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)

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.

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.

**Please read full Prescribing Information, including Boxed WARNINGS, and Medication Guide for SPRAVATO® and discuss any questions you may have with your healthcare provider.**




## Why should I sign this Form?

This Form gives your Healthcare Providers permission to use and share your medical information with the patient support programs offered by Johnson & Johnson.

### 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
- Service providers for the patient support programs. This includes subcontractors or healthcare providers helping J&J run the programs
- Providers of other sources of funding. This includes foundations and co-pay assistance providers
- Service providers maintaining, transmitting, de-identifying, aggregating, or analyzing data from J&J's 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's patient support programs

 **J&J and the other groups on this Form may share information about me in 2 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's 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's 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's 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's patient support programs that may be useful for my care




### 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 J&J's 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 patient support program from J&J

 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:

[Clear Form](#)

[Print Form](#)



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](https://SPRAVATOWithMePatientAuth.com)  
or scan the QR code



Data rates may apply