NOTE: PLEASE READ THE PATIENT ELIGIBILITY REQUIREMENTS ON THE NEXT PAGE PRIOR TO COMPLETING THIS FORM.

Janssen CarePath

Savings Program
2022 Patient Enrollment Form

Spravato® (esketamine) CIII
28 mg nasal spray

*Required

MyJanssenCarePath.com Phone: 877-CarePath (877-227-3728) Fax: 833-777-7282

PATIENT INFORMATION (*Required)

*Do you have a SPRAVATO® Savings Program card? ☐ Yes ☐ No

*If yes, provide 9-digit Savings Program medical claims member # **OR** 11-digit Savings Program pharmacy claims member # found on front of card _____

*FIRST NAME _____ *LAST NAME _____

*ADDRESS _____

ADDRESS LINE 2 _____

*CITY _____ *STATE _____ *ZIP _____

*SEX ☐ Male ☐ Female *DATE OF BIRTH (MM/DD/YYYY) _____ *PRIMARY PHONE (Best number to call 8:00 AM–8:00 PM ET, weekdays) _____

E-MAIL _____

*If you're unavailable when we call, is it ok for us to leave a message including the name of your medication? ☐ Yes ☐ No

*1. Do you have commercial or private health insurance that you will use for your Janssen medication? Examples are commercial insurance from a former/current employer, government employee health insurance, or insurance you buy privately or through the Health Insurance Marketplace

☐ 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 agree NOT to ask any government-funded healthcare program to cover any of the 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 agree that I will NOT seek payment from any government-funded healthcare program for my Janssen medication

☐ No, I may seek payment from a government-funded healthcare program for my Janssen medication

*3. Do you agree NOT to 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 agree that I will NOT submit any costs paid by this program as a claim

☐ No, I may submit costs paid by this program as a claim

Patient Assignment of Benefits Consent:

Do you authorize that each of your Janssen CarePath Savings Program out-of-pocket payment(s) be sent on your behalf to all provider(s) for payment of your out-of-pocket Janssen medication cost(s)?

☐ Yes, I authorize that each of my Janssen CarePath Savings Program out-of-pocket payment(s) be sent on my behalf to all provider(s) for payment of my out-of-pocket Janssen medication cost(s)†

☐ No, I do not authorize that each of my Janssen CarePath Savings Program out-of-pocket payment(s) be sent on my behalf to all provider(s) for payment of my out-of-pocket Janssen medication cost(s)

†You may, at any time, call Janssen CarePath and elect for the rebate check(s) to be sent directly to you.

PROVIDER INFORMATION (*Required)

☐ REFERRING PHYSICIAN ☐ TREATING PHYSICIAN

*PROVIDER FIRST NAME _____ *PROVIDER LAST NAME _____

*PRACTICE NAME _____ SITE PHONE _____

*PROVIDER ADDRESS _____

ADDRESS LINE 2 _____

*CITY _____ *STATE _____ *ZIP _____

By providing your information, you are requesting to enroll in the Janssen CarePath Savings Program for SPRAVATO®. The information you provide will be used by Johnson & Johnson Health Care Systems Inc., our affiliates, and the service providers supporting Janssen CarePath to administer the program, fulfill your request to enroll, and to provide benefits to you related to your use of the program. By enrolling, you acknowledge you have received your doctor's Notice of Privacy Practices, which describes how your information is used for treatment, payment, and healthcare operations purposes, and that limited Protected Health Information related to medication payment will be made available to and shared with your doctor to facilitate payment of program benefits. We may also use the information you provide to learn more about the people who use Janssen CarePath resources and to improve the information we provide to people who are enrolled in Janssen CarePath programs. Our Privacy Policy governs the use of the information you provide. By submitting this form to enroll in the Janssen CarePath Savings Program for SPRAVATO®, you certify that you have completed all of the information completely, accurately, and to the best of your knowledge, and that you have read, understand, and agree to the Terms and Conditions of the Janssen CarePath Savings Program for SPRAVATO®.

Fax or mail completed enrollment form to: Fax: 833-777-7282 Mail: Janssen CarePath Savings Program, PO Box 13135, La Jolla, CA 92037

My signature below certifies that I have completed all of the above sections completely, accurately, and to the best of my knowledge. I understand, accept, and comply with all program requirements provided on the reverse side and I understand that redeeming this benefit is consistent with the requirements of my health plan.

I will speak/have spoken with my healthcare professional to learn more about what is required to receive SPRAVATO® so that I can participate in the Savings Program.

PATIENT SIGNATURE _____ DATE _____ PATIENT NAME _____
If the patient cannot sign, patient's personal representative must sign below (Please print)

PATIENT NAME _____ BY _____
(Signature of person signing for patient)

RELATIONSHIP TO PATIENT AND AUTHORITY TO MAKE MEDICAL DECISIONS FOR PATIENT _____

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

For assistance or additional information, call 877-CarePath (877-227-3728), Monday–Friday, 8:00 AM–8:00 PM ET

Am I eligible?

You may be eligible for the Janssen CarePath Savings Program if you:

• Are age 18 or older and currently use commercial or private health insurance that covers SPRAVATO® (esketamine) Nasal Spray CIII.

• Are enrolled in the SPRAVATO® Risk Evaluation and Mitigation Strategy (REMS). Learn more at SpravatoREMS.com/Patients.

There is no income requirement. Janssen CarePath Savings Program for SPRAVATO® is based on medication costs only and does not include costs to give you your treatment.

Other Requirements:

- This program is only available to people age 18 or older using commercial or private health insurance for their Janssen medication. This includes plans from the Health Insurance Marketplace. This program is not for people who use any state or federal government-funded healthcare program. Examples of these programs are Medicare, Medicaid, TRICARE, Department of Defense, and Veterans Administration.
- You may not seek payment for the value received from this program from any health plan, patient assistance foundation, flexible spending account, or healthcare savings account.
- You must meet the program requirements every time you use the card.
- Program terms will expire at the end of each calendar year. The program may change or end without notice, including in specific states.
- To use this program, you must follow any health plan requirements, including telling your health plan how much co-payment support you get from this program. By getting a Savings Program benefit, you confirm that you have read, understood, and agree to the program requirements on this page, and you are giving permission for information about your Savings Program transactions to be shared with your healthcare provider(s). These transactions include rebates and any funds placed on the card or balance remaining on the card.
- Before you enroll in the program, you will be asked to provide personal information that may include your name, address, phone number, email address, and information related to your prescription medication insurance and treatment. This information is needed for Janssen Pharmaceuticals, Inc., the maker of SPRAVATO®, and our service providers to enroll you in the Janssen CarePath Savings Program. We may also use the information you give us to learn more about the people who use SPRAVATO®, and to improve the information we give them. Janssen Pharmaceuticals, Inc., will not share your information with anyone else except where legally allowed.
- If you use medical/primary insurance to pay for your medication, you need to submit a rebate request with an Explanation of Benefits (EOB) to get payment from the Savings Program. With your permission, your provider may submit the rebate request and EOB for you by mail or through an electronic billing system. Please make sure you and your provider know who will submit the rebate request. Rebate requests must be submitted within 270 days of the date of service.
- This program offer may not be used with any other coupon, discount, prescription savings card, free trial, or other offer. Offer good only in the United States and its territories. Void where prohibited, taxed, or limited by law.

You may end your participation in Janssen CarePath at any time by calling 877-CarePath (877-227-3728).

3 ways to enroll: Review the program requirements above, then choose the enrollment option you prefer:

Online:
MyJanssenCarePath.com

Phone:
877-CarePath (877-227-3728)

Form:
Complete and sign the reverse side of this form, and fax or mail to:
Fax: 833-777-7282 **OR** Mail: Janssen CarePath Savings Program
PO Box 13135
La Jolla, CA 92037

Please be aware that enrollment can take up to 2 business days from receipt of enrollment form.

NOTE: Your signature on the reverse side of this form certifies that you understand, accept, and comply with all requirements described above, and that your participation in the Program is consistent with the requirements of your health plan.

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

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**

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:

_____

janssen