

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 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 SPRAVATO 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 _____

Care Partner/Contact _____ Relationship to Patient _____
(A care partner/contact is someone who can be contacted in place of the patient.)

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

- I consent to receive voicemails from the SPRAVATO withMe program that include my medicine name and/or disease state.
- If I cannot be reached, I authorize SPRAVATO withMe to contact my care partner.
- I prefer and authorize SPRAVATO withMe to contact my care partner in place of me.

2. Text Message and Marketing Communications Opt-Ins (optional)

Text Message Opt-In

You can opt in to receive text messages from the SPRAVATO withMe program.

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

- OPT IN:** Yes, I would like to receive communications relating to my SPRAVATO[®] medicine.
- 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

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.

Spravato withMe Program Enrollment Form



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Patient First Name _____ Patient Last Name _____ DOB _____

3. SPRAVATO withMe Savings Program and Observation Rebate Program Enrollment Opt-In (optional)

SPRAVATO withMe Savings Program

Eligible commercially insured patients pay as little as \$10 per treatment for SPRAVATO® medicine 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 medicine 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, 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® medicine or treatment costs.
- I will NOT use any government-funded healthcare program† to cover any of my SPRAVATO® medicine or treatment costs.
- 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 spending account, or healthcare 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

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
- Inform my Healthcare Provider that I am enrolled in J&J's patient support programs
- Manage the J&J patient support programs
- Help verify and coordinate coverage for J&J medicines with my Insurers and Healthcare Providers
- 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
- Help with prescription or treatment location and associated scheduling
- Communicate with my Healthcare Providers about access, reimbursement, and fulfillment for my J&J medicine
- 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:



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
or scan the QR code



Data rates may apply.