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

Savings Program
2021 Patient Enrollment Form

*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 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

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.

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, and that I have read, understand, and agree to the Patient Authorization to release my Protected Health Information as indicated on pages 3 and 4 of this form, including but not limited to spoken or written facts about my health and payment benefits that I may have. It can include copies of records from my healthcare providers or health plans about my health or health care. I understand, accept, and comply with all program requirements provided on the next page 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.

☐ I would like to receive information and updates about SPRAVATO®.

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 accompanying 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

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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 individuals age 18 or older using commercial or private health insurance for their Janssen medication, including plans available through state and federal healthcare exchanges.** This program is not available to individuals who use any state or federal government-funded healthcare program to cover a portion of medication costs, such as Medicare, Medicaid, TRICARE, Department of Defense, or Veterans Administration.
- Out-of-pocket costs paid by this program may not be submitted 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).
- Your eligibility to use the Savings Program card is subject to meeting the program requirements at the time of each use.
- Program terms expire at the end of each calendar year. Program subject to change or discontinuation without notice, including in specific states.
- As a condition of participating in this program, you must ensure that you comply with any co-payment disclosure requirements of your insurance carrier or third-party payer, including disclosing to your insurer the amount of co-payment support you receive from this program. By receiving a Savings Program benefit, you confirm that you have read, understood, and agree to the program requirements shown on this page, and you are giving permission for information related to your Savings Program transactions, including rebates and any funds placed on or balance remaining on the Savings Program card, to be shared with your healthcare provider(s).
- Before you enroll in the program, it is important that you understand that you will be asked to provide personal information that may include your name, address, phone number, e-mail address, and information related to your prescription medication insurance and treatment. This information is necessary to permit Janssen Pharmaceuticals, Inc., the maker of SPRAVATO®, and companies that work with Janssen Pharmaceuticals, Inc., including our affiliates and our service providers, to fulfill your request to enroll 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 provide to people who are being treated with SPRAVATO®. Janssen Pharmaceuticals, Inc., will not share your information with anyone else except as required by law.
- If you use medical/primary insurance to pay for your medication, you are responsible for submitting a rebate request including an Explanation of Benefits (EOB) to receive payment under the Savings Program. At your direction, your provider may submit the rebate request and EOB on your behalf by mail or through an electronic billing system. Please ensure you and your provider coordinate who will submit the rebate request.
- This program offer may not be combined with any other coupon, discount, prescription savings card, free trial, or other offer. The selling, purchasing, trading, or counterfeiting of this card is prohibited. Offer good only in the United States and its territories. Void where prohibited, taxed, or otherwise restricted by law.

Janssen CarePath is in no way an extension of medical treatment provided by healthcare professionals to individual patients. You may discontinue your participation 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 previous page 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

NOTE: Your signature on the previous page 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.
- That you have read, understand, and agree to the Patient Authorization to release your Protected Health Information as indicated above, including but not limited to spoken or written facts about your health and payment benefits you may have. It can include copies of records from your healthcare providers or health plans about your health or health care.

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

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Janssen CarePath

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

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Janssen CarePath

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:

____

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