

Initiating Benefits  
Investigation

Helping you help your patients get started with  
the Janssen medication you prescribed

**Spravato**<sup>™</sup>  
(esketamine)   
nasal spray

## Completing the Benefits Investigation Form (BIF)

Once a treatment decision has been made to prescribe SPRAVATO™, use the BIF to provide information about your office and your patient for therapy with SPRAVATO™.

### Patient Information

- Please provide all required patient information, including date of birth
  - Have the patient check the appropriate box to indicate contact preference
- ! DON'T FORGET!** Patient must review and sign the Patient Authorization on pages 4 and 5.

### Insurance Information

- Fill in all required insurance information
- Include separate prescription drug insurance (if applicable)
- Provide Phone and Policy numbers

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**CarePath** UPDATE 1.19

Benefits Investigation Form

**Spravato™**  
(esketamine) Ⓢ  
nasal spray

**1. 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 \_\_\_\_\_

Patient Phone \_\_\_\_\_

Email \_\_\_\_\_

Caregiver \_\_\_\_\_  
(A caregiver/contact is someone who can be contacted in place of the patient.)

Relationship to Patient \_\_\_\_\_ Caregiver Phone \_\_\_\_\_

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.

**2. Insurance Information (Required)** Please provide insurance information for all health insurance coverage your patient may have.

Please see attached insurance card(s).

**Primary Medical Insurance**

Primary Insurance Carrier \_\_\_\_\_ Phone \_\_\_\_\_

Cardholder Name (First, MI, Last) \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

**Secondary Medical Insurance**

Secondary Insurance Carrier \_\_\_\_\_ Phone \_\_\_\_\_

Cardholder Name (First, MI, Last) \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

**Prescription Drug Insurance**

Prescription Drug Insurer \_\_\_\_\_ Card BIN # \_\_\_\_\_ Phone \_\_\_\_\_

Cardholder Name (First, MI, Last) \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

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

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**Important:** To ensure the patient's Verification of Benefits is provided in a timely manner, please complete ALL required fields highlighted in **BLUE**.

**Provider Information**


- Check the appropriate box:
  - Select “I am the Referring Physician” if you plan to refer your patient to a REMS-certified treatment center for SPRAVATO™ treatment
  - Select “I am the Prescribing & Treating Physician” if you plan to prescribe SPRAVATO™ and treat the patient at your REMS-certified healthcare setting
- Provide all required contact information
- List the Provider Name and an alternate Site Contact who is authorized to relay HCP orders to Janssen CarePath
- List accurate fax number where patient Verification of Benefits will be sent

**Treatment Location**


- Prescribing & Treating Physicians: check this box if the treatment location information is the same as the Provider Information in Section 3
- If the treatment location is not the same, provide treatment location contact information

**Treatment Location Support**

- Referring Physicians: check this box to request help identifying an appropriate treatment location for your patient



Benefits Investigation Form



**3. Provider Information (Required)**

I am the Referring Physician       I am the Prescribing & Treating Physician  
 Provider Name (First, Last) \_\_\_\_\_ Specialty (optional) \_\_\_\_\_  
 Site Name \_\_\_\_\_ Site Contact \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
 Email \_\_\_\_\_  
 NPI # \_\_\_\_\_ DEA # \_\_\_\_\_ State License # \_\_\_\_\_ Tax ID # \_\_\_\_\_  
 Phone \_\_\_\_\_ Fax \_\_\_\_\_  
 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.

**4. Product Acquisition Plan**

**Healthcare Setting or Pharmacy must be Risk Evaluation and Mitigation Strategy (REMS) certified prior to ordering and/or dispensing SPRAVATO™.**

 Medical Buy & Bill       Undecided  
 REMS-certified Pharmacy Name \_\_\_\_\_  
 Address \_\_\_\_\_ Address 2 \_\_\_\_\_  
 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 above.

**Location Information**

 Inpatient  Hospital Outpatient  Outpatient Clinic  Private Practice  Other \_\_\_\_\_  
 Prescriber Name (First, Last) \_\_\_\_\_  
 Specialty (optional) \_\_\_\_\_  
 Practice Name \_\_\_\_\_  
 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.

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

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**Product Acquisition Plan**

- Check the appropriate box to indicate the preferred method of product acquisition for your patient

**NOTE:** Select “Medical Buy & Bill” if you intend to purchase and store SPRAVATO™, and then administer the product to your patient. After your patient receives treatment, you will need to submit a claim for reimbursement to your patient’s healthcare insurance provider.

**! DON'T FORGET!** The healthcare setting or pharmacy must be Risk Evaluation and Mitigation Strategy (REMS)-certified prior to ordering and/or dispensing SPRAVATO™.

**Important:** To ensure the patient’s Verification of Benefits is provided in a timely manner, please complete ALL required fields highlighted in **BLUE**.

**Clinical Information**


- Fill out required information clinically appropriate for your patient
- Include Diagnosis/ICD-10 Code, Dosage Strengths, and Treatment History

**Prior Authorization**

- Prior Authorization support is provided with benefits investigation for Prescribing & Treating Physicians
- You may **OPT OUT** by checking this box. Please note—Referring Physicians are automatically opted out of prior authorization support

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Benefits Investigation Form



**6. 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

**Concomitant Oral Antidepressant:** \_\_\_\_\_

**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 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.**

The information requested above is for benefits investigation purposes only. This form does not constitute a valid prescription.

**7. 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.

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 844-777-2828. Our Privacy Policy, available at JanssenCarePath.com/Privacy-Policy, 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.

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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**Please see the accompanying full Prescribing Information, including Boxed WARNING and Medication Guide, for SPRAVATO™. Provide the Medication Guide to your patients and encourage discussion.**

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**Important:** To ensure the patient's Verification of Benefits is provided in a timely manner, please complete ALL required fields highlighted in BLUE.

**HIPAA Patient Authorization  
for Janssen CarePath**

- Have your patient read, sign, and date the Patient Authorization
  - Give your patient a copy of the signed HIPAA Patient Authorization form and keep the original for your records
- ! DON'T FORGET!** Have your patient check the box to **OPT IN** if he/she is interested in receiving information and updates about SPRAVATO™.

**HIPAA Patient Authorization  
for Janssen CarePath**

The below authorization is in connection with Janssen CarePath programs my doctor has discussed with me and I have agreed to be enrolled in.

I hereby authorize the use and/or disclosure of my private health information, described below, which includes "Protected Health Information" (PHI).

I understand that my Protected Health Information will not be used or disclosed by Janssen CarePath for any other purpose without my prior authorization unless permitted by law or unless information that specifically identifies me is removed. I understand that Janssen CarePath will make every effort to keep my information private. I understand that if my information is accidentally shared, federal privacy laws do not require that the person/party receiving it will not disclose 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 HIPAA Patient Authorization Form. My choice about whether to sign will not change the way my Healthcare Providers or Payer treat me. If I refuse to sign the HIPAA Patient Authorization Form, or cancel or revoke my authorization later, I understand that this means I will not be able to participate or receive assistance from Janssen CarePath.

**The following:**

1. My Healthcare Provider
2. Janssen CarePath
3. My Payer

**Description:** My "Person name, address, and contact information" (PHI) for Janssen CarePath. For my health information.

**The information:**

1. Enroll me in the program
2. Send me program information
3. Verify, in writing, my eligibility for the program
4. Identify my treatment options
5. Share with me my doctor's recommendations
6. In response to my questions, provide me with information about the program

I also authorize Janssen CarePath to evaluate Janssen CarePath programs for me.

**Redisclosure:** I understand that my Protected Health Information may be redisclosed by Janssen CarePath, for the purposes outlined above—to my health plan(s) or other third-party payer(s), my healthcare providers, and any individual I designate as a caregiver—and I specifically authorize such redisclosures.

I would like to receive information and updates about SPRAVATO™ (esketamine) Nasal Spray CIII.

Patient name \_\_\_\_\_ Date of birth (mm/dd/yyyy) \_\_\_\_\_

Patient address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Patient email \_\_\_\_\_

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:  
\_\_\_\_\_

Please call Janssen CarePath at 844-777-2828 or follow up with your doctor if you have questions about Janssen CarePath or this authorization.

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



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Fax the completed and signed Benefits Investigation Form to Janssen CarePath at **833-777-7282**.

**Important:** To ensure the patient's Verification of Benefits is provided in a timely manner, please complete ALL required fields highlighted in **BLUE**.

## Understanding Your Patients' Benefits

Following receipt of the BIF, Janssen CarePath will verify insurance benefits within 2 business days and provide your office with a Verification of Benefits (VOB).

### Patient Information

- Name and date of birth
- Service Request Number and date researched

### Payer Information

- Plan and policy information
- Investigated CPT code


### Treatment Location

- Name of the treatment location(s)
- Treatment location REMS certification status and payer network status


### Coverage for SPRAVATO™

- In-network and out-of-network benefit information is provided for:
  - Observation period
  - Physician purchase option through Medical Benefit
  - Pharmacy option through Medical and/or Prescription Drug Benefit
- Coverage details include:
  - Outcome
  - Deductible and amount met
  - Out-of-pocket maximum and amount met
  - Drug co-pay/coinsurance
  - Pharmacy cap and amount met
  - Initial coverage limit
  - True Out-of-pocket (Troop) cost
  - Medicaid spend-down and amount met

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### Verification of Benefits



Patient Information			
Patient Name: [Patient Name]			
Date of Birth: [Date of Birth]			
Service Request Number: [BI SR #]		Researched on: [Insert Date]	

THIS VERIFICATION OF BENEFITS IS NOT A GUARANTEE OF PAYMENT

Payer Information			
Payer: [Payer Name]		PBM: [PBM Name]	
Plan Name: [Plan Type]			
Group #: [Group #]		Payer Ranking: [Primary, Secondary]	
Member ID: [Member ID]		Phone Number: [Payer Phone Number]	
Policy Period: [Date—Date]		Procedure Code: [Insert CPT Code]	

	[Treatment Location #1 – Selected by HCP]	[Treatment Location #2]	[Treatment Location #3]
Treatment Location REMS Certification Status	[Certified, Not Certified, N/A]	[Certified, Not Certified, N/A]	[Certified, Not Certified, N/A]
Treatment Location Payer Network Status	[Yes, No, Unknown]	[Yes, No, Unknown, N/A]	[Yes, No, Unknown, N/A]

	Observation Period Benefit		Physician Purchase Option Through Major Medical Benefit		Pharmacy Option Through Major Medical Benefit		Pharmacy Option Through Prescription Drug Benefit	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Outcome								
Deductible								
Deductible Met								
Out-of-pocket Maximum								
Out-of-pocket Maximum Met								
Drug Co-pay/Coinsurance								
Pharmacy Cap								
Pharmacy Cap Met								
Initial Coverage Limit								
True Out-of-pocket (Troop)								
Medicaid Spend-down								
Medicaid Spend-down Met								

Please see full Prescribing Information, including Boxed WARNING and Medication Guide for SPRAVATO™, available at [JanssenCarePath.com](http://JanssenCarePath.com). Provide the Medication Guide to your patients and encourage discussion.

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**Prior Authorization (PA) Requirements**

- PA requirements for Major Medical Benefit and Prescription Drug Benefit:
  - Prior authorization/pre-determination
  - Required documents
  - Turnaround time
  - Submission method
  - Attention to
  - Phone and fax numbers
  - PA status
  - PA effective—expiration date



**In-network Pharmacies**

- Pharmacy name(s)
- Pharmacy phone number(s)
- Payer status
- REMS certification status

**Observation Period Benefit Details**

- Notes providing additional information related to the patient’s observation period benefits

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### Verification of Benefits

Prior Authorization (PA) Requirements			
	Major Medical Benefit	Prescription Drug Benefit	
Prior Auth/Pre-determination Required			
Required Documentation			
Turnaround Time			
Submission Method			
Attention to			
Phone			
Fax			
PA Status			
PA Effective—Expiration Date			

In-network Pharmacies			
Pharmacy Name	Pharmacy Phone Number	Payer Status	REMS Certification Status
[Pharmacy option # 1]	[Insert Ph. #]	[In Network, Out of Network, Preferred In-Network]	[Certified, Not Certified]
[Pharmacy option # 2]	[Insert Ph. #]	[In Network, Out of Network, Preferred In-Network]	[Certified, Not Certified]
[Pharmacy option # 3]	[Insert Ph. #]	[In Network, Out of Network, Preferred In-Network]	[Certified, Not Certified]



Observation Period Benefit Details

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### Verification of Benefits

Additional Information

**Additional Information**

- Notes providing additional information related to the patient’s insurance benefits

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Third-party reimbursement is affected by many factors. This document and the information and assistance provided by Janssen CarePath are presented for informational purposes only. They do not constitute reimbursement or legal advice. Janssen CarePath does not promise or guarantee coverage, levels of reimbursement, or payment.

Similarly, all CPT® and HCPCS codes are supplied for informational purposes only and represent no statement, promise, or guarantee, expressed or implied, by Janssen or its third-party service providers that these codes will be appropriate or that reimbursement will be made. The fact that a drug, device, procedure, or service is assigned an HCPCS code and a payment rate does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the Medicare program.

Laws, regulations, and policies concerning reimbursement are complex and are updated frequently. Accordingly, the information may not be current or comprehensive. Janssen and its third-party service providers strongly recommend you consult your payer for its most current coverage, reimbursement, and coding policies. Janssen and its third-party service providers make no representations or warranties, expressed or implied, as to the accuracy of the information provided. In no event shall the third-party service providers or Janssen, or their employees or agents, be liable for any damages resulting from or relating to any information provided by, or accessed to or through, Janssen CarePath. All HCPs and other users of this information agree that they accept responsibility for the use of this program.

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## We can help make it simple for you to help your patients



**Access support**  
to help navigate  
payer processes



**Affordability support**  
to help your patients start and stay on  
the Janssen medication you prescribe



**Treatment support**  
to help your patients get informed  
and stay on prescribed treatment



**Need  
help?**

**Call 844-777-2828**

Monday–Friday, 8:00 AM–8:00 PM ET

Multilingual phone support available

**Visit: [JanssenCarePath.com/hcp/Spravato](https://www.JanssenCarePath.com/hcp/Spravato)**

Please see the full [Prescribing Information](#), including Boxed WARNINGS and [Medication Guide](#), for SPRAVATO<sup>™</sup>.  
Provide the Medication Guide to your patients and encourage discussion.