

Initiating Benefits  
Investigation

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



## 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®.

### 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. Be sure to indicate how you plan to bill by checking “CMS-1500,” “UB-04,” or “Unsure”
- 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

Janssen UPDATE TEXT ID CarePath

Benefits Investigation Form

Complete and fax this form to Janssen CarePath at 833-777-7282.

**Spravato**®  
(esketamine)   
nasal spray

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**1. Provider Information (Required)**

I am the Referring Physician

I am the Prescribing & Treating Physician  
If Prescribing & Treating Physician, how do you plan to bill?  CMS-1500  UB-04  Unsure

Provider Name (First, Last) \_\_\_\_\_ Specialty (optional) \_\_\_\_\_

Site Name \_\_\_\_\_ Site Contact \_\_\_\_\_

Address \_\_\_\_\_

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

Email \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Emergency After Hours Phone \_\_\_\_\_

NPI # \_\_\_\_\_ DEA # \_\_\_\_\_ State License # \_\_\_\_\_ Tax ID # \_\_\_\_\_  
(Please provide the NPI # associated with the billing method.)

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.

**2. 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.

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

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### 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

**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

### Treatment Location

- Prescribing & Treating Physicians: check this box if the treatment location information is the same as the Provider Information on page 1
- 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

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**3. 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<sup>®</sup>**

Dose Strengths to Investigate:  84 mg  56 mg  Both      Concomitant Oral Antidepressant: \_\_\_\_\_

**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.**

**Treatment History:** Select therapies previously prescribed within the current depressive episode.

Celexa<sup>®</sup> (citalopram)     Pexeva<sup>®</sup> (paroxetine mesylate)     Cymbalta<sup>®</sup> (duloxetine)     Fetzima<sup>®</sup> (levomilnacipran)

Lexapro<sup>®</sup> (escitalopram)     Prozac<sup>®</sup> (fluoxetine)     Effexor<sup>®</sup> (venlafaxine)     Khedezla<sup>®</sup> (desvenlafaxine succinate)

Paxil<sup>®</sup> (paroxetine)     Zoloft<sup>®</sup> (sertraline)     Effexor XR<sup>®</sup> (venlafaxine XR)     Pristiq<sup>®</sup> (desvenlafaxine)

Other: \_\_\_\_\_

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

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**4. Product Acquisition Plan**

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

Medical Buy & Bill       Undecided

REMS-certified Pharmacy Name \_\_\_\_\_

Address \_\_\_\_\_ Address 2 \_\_\_\_\_

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

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**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 on page 1.

**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.

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**Please see the accompanying full Prescribing Information, including Boxed WARNINGS and Medication Guide, for SPRAVATO<sup>®</sup>. 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<sup>®</sup>, 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<sup>®</sup>.

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

**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 5 and 6.


**Insurance Information**

- Fill in all required insurance information
  - Please note that some fields are optional
- Include separate prescription drug insurance (if applicable)
- Provide Phone and Policy numbers
- Check here if you do not want Janssen CarePath to investigate out-of-network benefits for your patient

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**Benefits Investigation Form**

Complete and fax this form to Janssen CarePath at 833-777-7282.



**6. 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 \_\_\_\_\_  
 Primary Phone \_\_\_\_\_ Secondary Phone (optional) \_\_\_\_\_ Best Time to Contact \_\_\_\_\_  
 Email \_\_\_\_\_  
 Caregiver/Contact \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
(A caregiver/contact is someone who can be contacted in place of the patient.)  
 Primary Phone \_\_\_\_\_ Secondary Phone (optional) \_\_\_\_\_ Best Time to Contact \_\_\_\_\_  
 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.

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

Please see attached front and back copy of insurance card(s). \*Optional information

**Primary Medical Insurance**

Primary Insurance Carrier \_\_\_\_\_ Phone \_\_\_\_\_  
 Cardholder Name (First, MI, Last) \_\_\_\_\_  
 \*Relationship to Cardholder \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

**Secondary Medical Insurance**

Secondary Insurance Carrier \_\_\_\_\_ Phone \_\_\_\_\_  
 Cardholder Name (First, MI, Last) \_\_\_\_\_  
 \*Relationship to Cardholder \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

**Prescription Drug Insurance**

Prescription Drug Insurer \_\_\_\_\_ Card BIN # \_\_\_\_\_ Phone \_\_\_\_\_  
 Cardholder Name (First, MI, Last) \_\_\_\_\_  
 \*Relationship to Cardholder \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Please do not investigate out-of-network benefits.

Please see the accompanying full Prescribing Information, including Boxed WARNINGS and Medication Guide, for SPRAVATO<sup>®</sup>. 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**.

**Janssen CarePath Savings Program**

- The patient can check this box to register for the Janssen CarePath Savings Program for SPRAVATO<sup>®</sup> if the results of their benefits investigation determine they have commercial or private health insurance that covers a portion of their medication costs
  - Patient must answer all eligibility questions in order to register for the Savings Program

- Have the patient select their preference for receiving their Savings Program rebate
  - Patient should select “Send Funds to Provider” if you will be submitting claims on their behalf

**NOTE:** If the patient submits a claim, they will receive the payment instead of you. Please ensure you have discussed the patient’s payment preference with them and that you will be submitting claims on their behalf.


- Patient should select “Mail Rebate Check to Patient” if the patient intends to submit a rebate form to receive a rebate check by mail


**! DON'T FORGET!** The patient may, at any time, call Janssen CarePath to change their payment selection.

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Benefits Investigation Form

Complete and fax this form to Janssen CarePath at 833-777-7282.



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(esketamine)   
nasal spray

**8. Janssen CarePath Savings Program (Optional)**

**Eligible patients using commercial insurance can save on out-of-pocket Janssen medication costs. See program requirements at [Spravato.JanssenCarePathSavings.com](http://Spravato.JanssenCarePathSavings.com).**

I would like Janssen CarePath to check my eligibility for and enroll me into the Janssen CarePath Savings Program if the results of this benefits investigation determine I have commercial or private health insurance that covers a portion of my medication costs.

**Who should receive your Savings Program rebate payment?**

**Send Funds to Provider** (By selecting this option, you must share your Savings Program card information with your provider.)  
By selecting this option, you understand and authorize that your Janssen CarePath Savings Program out-of-pocket payment will be sent to the provider who submits the claim on your behalf for payment of your out-of-pocket Janssen medication costs. If your doctor's office does not accept your Savings Program card information, you can always submit a rebate form and proof of medication payment to receive your rebate. You may, at any time, call Janssen CarePath to change your selection.

**Mail Rebate Check to Patient** (By selecting this option, you must submit a rebate form, including proof of payment, to receive a rebate check by mail.)  
For each Savings Program request, you will need to submit a rebate form, including proof of payment. If you used medical insurance to pay for your medication, you will also need to submit an Explanation of Benefits (EOB). For each request you submit, we will mail you your out-of-pocket payment via check with a letter notifying you that your request was successfully processed. You will be responsible for upfront payment at time of treatment.  
If you use your pharmacy/prescription insurance to pay for your medication, you will receive instant savings, regardless of your selection above. If your pharmacy can't process your Janssen CarePath Savings Program card, you can submit a rebate form and proof of medication payment to receive your rebate.

**Eligibility Questions**

**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-subsidized 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-subsidized program for my Janssen medication

**No**, I may seek reimbursement from a state or federal government-subsidized 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

Please see the accompanying full Prescribing Information, including Boxed WARNINGS and Medication Guide, for SPRAVATO<sup>®</sup>. Provide the Medication Guide to your patients and encourage discussion.

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### 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<sup>®</sup>.

**Janssen CarePath**      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" as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that Protects my Personal Health Information. I understand that my Personal Health Information is protected by the Privacy-Policy of Janssen CarePath.

**The following information will be used and/or disclosed:**

1. My Personal Health Information for the purpose of providing me with the services and/or products that I have requested.
2. The appointment and/or services that I have requested.
3. My health information for the purpose of providing me with the services and/or products that I have requested.

**The following information will be used and/or disclosed:**

1. My Personal Health Information for the purpose of providing me with the services and/or products that I have requested.
2. Janssen CarePath for the purpose of providing me with the services and/or products that I have requested.
3. My Personal Health Information for the purpose of providing me with the services and/or products that I have requested.

**Description:** My Personal Health Information, including my name, address, telephone number, and other identifying information.

**The information will be used and/or disclosed for the following purposes:**

1. Enroll me in the Janssen CarePath program.
2. Send me information about the Janssen CarePath program.
3. Verify, in writing, my eligibility for the Janssen CarePath program.
4. Identify me as a patient of the Janssen CarePath program.
5. Share with other healthcare providers for my care.
6. In response to my request for information.

I also authorize Janssen CarePath to evaluate my health information for the purpose of providing me with the services and/or products that I have requested.

**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<sup>®</sup> (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 WARNINGS and Medication Guide for SPRAVATO<sup>®</sup>, 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**.

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

## Case Information

Includes key information including:

- Product Name
- Date Benefits Verified
- Dosage Form and Strength
- Primary and Secondary Diagnoses
- Prescriber/Referring Provider Name and Practice Name
- General Notes


## Primary Medical Insurance

- Outcome (prior authorization coverage)
- Member Status

## Coverage Summary

Provides key details including:

- Product J-Code
- Availability of Medical Buy & Bill and Medical Assignment of Benefits Coverage
- Coverage (Major Medical, Behavioral Health)
- Behavioral Health Organization Name, if applicable
- Prior Authorization/Pre-determination/Pre-certification Required
- Required Documentation
- Payer Decision Turnaround Time and Submission Method

janssen CarePath   Spravato (esketamine)  Verification of Benefits			
Page 1 of 3		Patient Name: <Data>	
		Patient DOB: <Data>	
		SR#: <Data>	
Case Information			
Product Name:			
Date Benefits Verified:		Dosage Form & Strength:	
Primary Diagnosis:		Secondary Diagnosis:	
Prescriber/Referring Provider Name:			
Practice/Referring Practice Name:			
General Notes			
Treatment Information			
[Treatment Location #1 – Selected by HCP]		[Treatment Location #2]	[Treatment Location #3]
Treatment Location REMS Certification Status	[Certified, Not Certified]	[Certified, Not Certified]	[Certified, Not Certified]
Treatment Location Payer Network Status	[In Network, Out of Network]	[In Network, Out of Network]	[In Network, Out of Network]
Primary Medical Insurance			
Outcome:		Member Status:	
Coverage Summary			
Product J-Code:		Availability of Medical Buy & Bill: [Yes, No]	
		Availability of Medical Assignment of Benefits Coverage: [Yes, No]	
Coverage: [Major Medical, Behavioral Health]			
If applicable, Behavioral Health Organization Name:			
[Prior Authorization/Pre-determination/Pre-certification] Required:			
Required Documentation:			
Payer Decision Turnaround Time:		Submission Method:	
Contact Information			
Attention to:		Fax:	
		Phone:	
PA on File: [Yes, No]		[Prior Authorization/Pre-determination/Pre-certification] ID:	
[Prior Authorization/Pre-determination/Pre-certification] Effective & Expiration Dates:			
[Prior Authorization/Pre-determination/Pre-certification] Process:			
Plan-Specific Details			
Quantity Limit:	In Network: [Covered, Not Covered]	Out of Network: [Covered, Not Covered]	
Deductible			
Deductible Met			
Out-of-pocket Maximum			
Out-of-pocket Maximum Met			
Co-pay/Coinsurance			
Please see full Prescribing Information, including Boxed WARNINGS and Medication Guide for SPRAVATO <sup>®</sup> , available at JanssenCarePath.com. Provide the Medication Guide to your patients and encourage discussion.			
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## Header

- Patient Name and Date of Birth
- Service Request Number

## Treatment Information

- Name of Treatment Location(s)
- Treatment Location REMS Certification Status and Payer Network Status

## Contact Information

- Attention to
- Fax and Phone Numbers
- PA on File
- Prior Authorization/Pre-determination/Pre-certification: ID, Effective and Expiration Dates, and Process

## Plan-Specific Details

- Quantity Limit
  - In Network and Out of Network:
    - Deductible and amount met
    - Out-of-pocket maximum and amount met
    - Co-pay/Coinsurance
- (continued on next page)

**Plan-Specific Details (cont'd)**

- Payer Provided Medical Additional Instructions
- Plan and Policy information


**Primary Pharmacy Insurance**

- Outcome (prior authorization coverage)
- Member Status

**Coverage Summary**

Provides key details including:

- Product NDC
- Pharmacy Coverage
- Prior Authorization/Pre-determination/Pre-certification Required
- Required Documentation
- Turnaround Time and Submission Method

janssen CarePath   Spravato (esketamine)  Verification of Benefits		
Page 2 of 3		
Patient Name: <Data> Patient DOB: <Data> SR#: <Data>		
Payer Provided Medical Additional Instructions:		
Payer Name:	Plan Type:	
Policy Number:	Member ID Number:	
Policy Effective Date:	Policy End Date:	
Primary Payer Contact:	Primary Payer Phone:	
<b>Administration Overview: Observation Period</b> [insert cover codes only]		
Coverage: [Major Medical, Behavioral Health]	In Network: [Covered, Not Covered, Unknown]	Out of Network: [Covered, Not Covered, Unknown]
Deductible		
Deductible Met		
Out-of-pocket Maximum		
Out-of-pocket Maximum Met		
Co-pay/Coinsurance		
Office Visit		
Payer Provided Reimbursement Code Notes:		
<b>Primary Pharmacy Insurance</b>		
Outcome:	Member Status:	
<b>Coverage Summary</b>		
Product NDC:	Pharmacy Coverage: [Yes, No]	
	[Prior Authorization/Pre-determination/Pre-certification] Required: [Yes, No]	
Required Documentation:		
Turnaround Time:	Submission Method:	
<b>Contact Information</b>		
Attention to:	Fax:	
	Phone:	
PA on File: [Yes, No]	[Prior Authorization/Pre-determination/Pre-certification] ID:	
[Prior Authorization/Pre-determination/Pre-certification] Effective & Expiration Dates:		
[Prior Authorization/Pre-determination/Pre-certification] Process:		
<b>Plan-Specific Details</b>		
Quantity Limit:	Deductible:	Deductible Met:
Out-of-pocket Maximum:	Out-of-pocket Maximum Met:	Co-pay/Coinsurance:
Please see full Prescribing Information, including Boxed WARNINGS and Medication Guide for SPRAVATO <sup>®</sup> , available at JanssenCarePath.com. Provide the Medication Guide to your patients and encourage discussion.		
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**Administration Overview: Observation Period**

- Coverage (Major Medical, Behavioral Health)
- In Network and Out of Network:
  - Deductible and amount met
  - Out-of-pocket Maximum and amount met
  - Co-pay/Coinsurance
  - Office Visit
  - Payer Provided Reimbursement Code Notes

**Contact Information**

- Attention to
- Fax and Phone Numbers
- PA on File
- Prior Authorization/Pre-determination/Pre-certification: ID, Effective & Expiration Dates, and Process

**Plan-Specific Details**



- Quantity Limit
- Deductible and amount met
- Out-of-pocket Maximum and amount met
- Co-pay/Coinsurance

(continued on next page)



**Plan-Specific Details (cont'd)**

- Payer Provided Pharmacy Additional Instructions
- Plan and Policy information

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**Verification of Benefits**

Patient Name: <Data>  
Patient DOB: <Data>  
SR#: <Data>

**Payer Provided Pharmacy Additional Instructions:**

<b>Payer Name:</b>		<b>Plan Type:</b>		
<b>Policy Number:</b>		<b>Member ID Number:</b>		
<b>Policy Effective Date:</b>		<b>Policy End Date:</b>		
<b>Primary Payer Contact:</b>		<b>Primary Payer Phone:</b>		
Pharmacy Name	Pharmacy Phone	Payer Status	Product Acquisition Method	REMS Certification Status
[Pharmacy Option #1]	[Insert Phone #]	[In Network/Out of Network]	[Medical, Rx, Both]	[Certified/Not Certified]
[Pharmacy Option #2]	[Insert Phone #]	[In Network/Out of Network]	[Medical, Rx, Both]	[Certified/Not Certified]
[Pharmacy Option #3]	[Insert Phone #]	[In Network/Out of Network]	[Medical, Rx, Both]	[Certified/Not Certified]

**Pharmacy Notes:**

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**Pharmacy Information**

- Name
- Phone
- Payer Status
- Product Acquisition Method
- REMS Certification Status
- Pharmacy Notes

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