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 in federal laws called the Privacy Regulations developed under the Health Insurance Portability and Accountability Act of 1996 (as amended, "HIPAA"). In general terms, I understand that Protected Health Information is health information that identifies me or that could be used to identify me. I understand that this authorization is voluntary. Our Privacy Policy governs the use of the information you provide.

The following person(s) or class of persons are authorized to share my information:

1. Physicians, pharmacists, other healthcare providers or support staff who have provided or will provide treatment or services to me (referred to as "My Healthcare Providers")
2. The approved third-party service providers administering and supporting Janssen CarePath offerings, under contract with Janssen Pharmaceuticals, Inc. These service providers are authorized to manage, administer, and/or support Janssen CarePath programs, including but not limited to SpravatoESubmission.com and MySpravatoConsent.com (referred to as "Janssen CarePath")
3. My health plan or other third-party payer (referred to as "My Payer")

The following person(s) or class of persons are authorized to receive and use my information:

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

Description of the information that may be used and/or shared:

My "Personal Health Information," which includes my diagnosis, prescribed therapy, insurance information, name, address, phone number, and a description of the resources I have requested or received from Janssen CarePath. For prescribed therapies, I understand that the information disclosed about me may include mental health information and/or records.

The information will be used and/or shared for the following purpose(s) as applicable:

1. Enroll me in, determine my eligibility for, and contact me about Janssen medication support programs
2. Send me requested educational materials, information, and resources related to the Janssen CarePath program or my Janssen medication
3. Verify, investigate, assist with, and coordinate my coverage for my Janssen medication with My Payer
4. Identify treatment location and/or provide information and assistance to help my transition to my next treatment location
5. Share with my Healthcare Provider(s) information generated by Janssen CarePath that may be useful for my care
6. In response to a court order, subpoena, or otherwise required by law

I also authorize Janssen CarePath to de-identify and use my health information to improve, develop and evaluate Janssen CarePath, its offerings and materials, and to evaluate patient access to and adherence to my Janssen medication.

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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.

1. I understand that I am entitled to a signed copy of this authorization.
2. I understand that this authorization shall expire either when I stop receiving Janssen CarePath resources or 10 years from the date of this authorization, whichever occurs first.
3. I understand that I may cancel or revoke this authorization at any time by notifying Janssen CarePath in writing at Janssen CarePath, P.O. Box 13135, La Jolla, CA 92037. I understand this will not affect information used and disclosed prior to receipt of my cancellation or revocation.
4. I understand that I have the right to review my health information that has been disclosed upon written request to Janssen CarePath, P.O. Box 13135, La Jolla, CA 92037.

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

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