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

Janssen CarePath

Savings Program
2019 Patient Registration Form

Spravato™ (esketamine) CIII nasal spray

*Required

Register.JanssenCarePathSavings.com Phone: 844-777-2828 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-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

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.

By providing your information, you are requesting to register for 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 register, and to provide benefits to you related to your use of the program. By registering, 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 registered for Janssen CarePath programs. Our Privacy Policy governs the use of the information you provide. By submitting this form to register for 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 registration 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 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 844-777-2828, Monday–Friday, 8:00 AM–8:00 PM ET

Patient Eligibility Requirements for Janssen CarePath Savings Program

Benefits are available to individuals who are age 18 or older and currently use commercial or private health insurance to cover a portion of the medication costs for SPRAVATO™ (esketamine) Nasal Spray CIII. 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. Before the calendar year ends, you will receive information and eligibility requirements for continued participation. 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 participating in the program, 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 register for 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 register for 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 844-777-2828.

3 ways to register: Review the program requirements above, then choose the registration option you prefer:

Online:
Register.JanssenCarePathSavings.com

Phone:
844-777-2828

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

Janssen CarePath

HIPAA Patient Authorization for Janssen CarePath

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. Register 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.

Janssen CarePath

HIPAA Patient Authorization for Janssen CarePath

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.

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

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