

Patient Cost Support Enrollment Form

TO BE COMPLETED BY THE PROVIDER

Provider: Help your patient sign up for cost support by completing the Prescriber Information section and providing the form to your patient to complete the patient sections. Completed forms can be uploaded to [Portal.JNJwithMe.com](https://portal.jnjwithme.com).

The information you provide will be used by Johnson & Johnson Health Care Systems Inc., our affiliates, and our service providers for your patient's enrollment and participation in SPRAVATO withMe. Our Privacy Policy, available at [InnovativeMedicine.JNJ.com/us/privacy-policy](https://www.innovativemedicine.com/us/privacy-policy), further governs the use of the information you provide.

Prescriber Information

 **Required information in order to process this form.**

I represent that I have authorization from the patient that complies with state and federal law, and permits me to provide the patient information on this form for the purpose of enrolling the patient in the SPRAVATO withMe Savings Program and Observation Rebate Program.

Prescriber First Name _____ Prescriber Last Name _____

Site Name _____

Site Contact First Name _____ Site Contact Last Name _____

Site Address _____

Site City _____ Site State _____ Site ZIP _____

Site Phone _____ Site Fax _____ Prescriber NPI # _____

TO BE COMPLETED BY THE PATIENT

Patient: Complete this form to enroll in SPRAVATO withMe cost support. For assistance, call 844-4S-WITHME (844-479-4846).

The information you provide will be used by Johnson & Johnson Health Care Systems Inc., our affiliates, and our service providers for your enrollment and participation in SPRAVATO withMe, and for any optional requests you may select. Our Privacy Policy, available at [InnovativeMedicine.JNJ.com/us/privacy-policy](https://www.innovativemedicine.com/us/privacy-policy), further governs the use of the information you provide. Your provider will submit this form to SPRAVATO withMe on your behalf.

Patient Information

 **Required information in order to process this form.**

By providing consent, you agree to the collection and use of your Sensitive Personal Information (SPI). Examples of SPI may include, but are not limited to, health-related information. We use this information consistent with our Privacy Policy, including to personalize the information you receive, to fulfill any requests you submit, and to research, develop, and improve our products and services.

Patient First Name _____ Patient Last Name _____ Sex: M F

Date of Birth (mm/dd/yyyy) _____ Preferred Language If Not English: _____

Patient Address _____

Patient City _____ Patient State _____ Patient ZIP _____

Preferred Patient Phone _____ (Cell Home)

Patient Email _____

Please read the full Prescribing Information, including Boxed WARNINGS, and Medication Guide for SPRAVATO[®] and discuss any questions you may have with your healthcare provider.

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SPRAVATO withMe Savings Program and Observation Rebate Program Enrollment

SPRAVATO withMe Savings Program

Eligible commercially insured patients pay as little as \$10 per treatment for SPRAVATO[®] medicine costs. Maximum program benefit per calendar year and program limits shall apply. Treatment may include up to three devices administered on the same day. Depending on your health insurance plan, savings may apply toward co-pay, co-insurance, or deductible. There is a program benefit limit of list price of the medicine and a quantity limit of three devices per day or 23 devices in a 24-day period. There is a quantity limit of 24 devices in a 24-day period for one use per lifetime. Terms expire at the end of each calendar year. Offer subject to change or end without notice. Restrictions, including monthly maximums, may apply. Program does not cover the cost of treatment observation. Participate without sharing your income information. See program requirements at [Spravato.com/SavingsRequirements](https://spravato.com/SavingsRequirements).

SPRAVATO withMe Observation Rebate Program

Eligible commercially insured patients pay \$0 after rebate to patient for observation of each treatment. Maximum program benefit per calendar year shall apply. Offer subject to change or end without notice. Not valid for residents of MA, MN, or RI. Participate without sharing your income information. See full program requirements at [Spravato.com/Observation](https://spravato.com/Observation).

By attesting to the statements below, I authorize SPRAVATO withMe to check my eligibility for the SPRAVATO withMe Savings Program and the SPRAVATO withMe Observation Rebate Program and enroll me in the Programs, if eligible.

I attest that:

- I have commercial or private health insurance* that I will use for my SPRAVATO[®] medicine or treatment costs.
- I will NOT use any government-funded healthcare program† to cover any of my SPRAVATO[®] medicine or treatment costs.
- I will NOT submit any amounts paid or reimbursed by these programs as a claim for payment to any health plan, patient assistance foundation, flexible spending account, or healthcare savings account.

*Examples are commercial insurance from a current/former employer, government employee health insurance, or insurance the patient buys privately or through the Health Insurance Marketplace.

†Examples are Medicare Parts A, B, C (also known as Medicare Advantage Plan), D, and Medicare Supplement, Medicaid, TRICARE, Department of Defense, or Veterans Administration.

The support and resources provided by SPRAVATO withMe are not intended to provide medical advice, replace a treatment plan you receive from your doctor or nurse, or serve as a reason for you to start or stay on treatment.

Please read the full Prescribing Information, including Boxed WARNINGS, and Medication Guide for SPRAVATO[®] and discuss any questions you may have with your healthcare provider.