Spravato withMe

Savings Program
844-4S-WITHME (844-479-4846)
Monday–Friday, 8:00 AM–8:00 PM ET

Spravato® (esketamine) CIII
28 mg nasal spray

Medical Benefit Rebate Form

Complete this side of the form only if you are submitting an **Explanation of Benefits (EOB)** for a rebate check **to be sent directly to the patient**.

Receive a Rebate in 4 Easy Steps

1. You must be enrolled in the SPRAVATO withMe Savings Program before your treatment date in order to receive a rebate for your SPRAVATO® medication. You can enroll online at **SPRAVATOwithMePatientAuth.com** or by calling 844-4S-WITHME (844-479-4846). Rebate requests must be submitted within 270 days of the date of service.
2. Use your SPRAVATO withMe Savings Program card to complete the information below. Sign the form.
3. Include a copy of the following documents:
   - Explanation of Benefits (EOB) from your primary insurance provider (as well as any secondary insurance provider, if applicable);
   - Receipt from the treatment provider indicating proof of payment of your out-of-pocket SPRAVATO® medication costs. Valid receipt will include your name, medication (name, billing code, and NDC#), date, and amount of out-of-pocket responsibility paid for your medication.

   If you do not have proof of payment for the medication, you must obtain your treatment location representative's signature below.
4. Submit this signed form by fax or mail along with EOB and proof of payment (see below for details). Eligible patients will receive a rebate check in about three weeks.

If you are submitting a **pharmacy receipt** and want to receive a rebate check, only complete the Pharmacy Benefit Rebate Form on the next page.

Complete the information below. *Required

The information you provide will only be used by Johnson & Johnson Health Care Systems Inc., our affiliates, and our service providers, to provide benefits to you related to your participation in the SPRAVATO withMe Savings Program. If you want to stop receiving this information or service, you may withdraw from the program by calling 844-4S-WITHME (844-479-4846), Monday–Friday, 8:00 AM–8:00 PM ET. Our **Privacy Policy** governs the use of the information you provide.

☐ 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, fulfill any requests you submit, and to research, develop, and improve our products and services. By checking the box, you indicate that you read, understand, and agree to such collection and use of your SPI.

*Name _____ Sex ☐ Male ☐ Female

*Date of Birth (mm/dd/yyyy) _____

E-mail _____

*Phone _____

*Address _____

*City _____

*State _____

*ZIP _____

*11-digit Savings Program medical claims member # found on the front of the Savings Program card

This program is only for people age 18 or older using commercial or private health insurance who must pay an out-of-pocket cost for their prescribed SPRAVATO®. This includes plans from the Health Insurance Marketplace. This program is not for people who use any state or federal government-funded healthcare program. Examples of these programs are Medicare, Medicaid, TRICARE, Department of Defense, and Veterans Administration. You may not seek payment for the value received from this program from any health plan, patient assistance foundation, flexible spending account, or healthcare savings account.

You must meet the program requirements every time you use the Savings Program. Program terms will expire at the end of each calendar year. The program may change or end without notice, including in specific states. Program participants are subject to an annual maximum benefit. Program benefits are set at the discretion of Johnson & Johnson and may change without notice.

To use this program, you must follow any health plan requirements, including telling your health plan how much co-payment support you get from this program, if required. By using the Savings Program, you confirm that you have read, understood, and agree to the program requirements, and you are giving permission for information related to your Savings Program transactions to be shared with your healthcare provider(s). These transactions include rebates and any funds placed on the card or balance remaining on the card. Offer good only in the United States and its territories. Void where prohibited, taxed, or limited by law. REBATE FORM CANNOT BE BOUGHT, TRANSFERRED, OR SOLD. REBATE FORM CANNOT BE COMBINED WITH ANY OTHER OFFER, DISCOUNT, PRESCRIPTION SAVINGS CARD, OR FREE TRIAL. Use of this program is subject to the program requirements, which can be found at **Spravato.com/SavingsRequirements**.

By signing, dating, and submitting this form, you confirm that **you**:

- **have enrolled in the SPRAVATO withMe Savings Program and have your Savings Program card.**
  Note: SPRAVATO withMe cannot process this rebate form if you do not have your Savings Program card; and
- meet the program requirements of the Savings Program, which may also be found at **Spravato.com/SavingsRequirements**

*Patient Signature _____ *Date _____

Treatment location representative signature required ONLY if proof of payment is not provided with rebate request. By signing below, you are confirming the patient has paid for their out-of-pocket medication costs and was treated with SPRAVATO® on the date below.

*Treatment Location Representative Signature _____ *Print Name _____ *Date _____

*Treatment Location Name _____ *Date of Treatment _____

You can submit by fax or by mail:

Fax:
844-584-1453

Mail:
SPRAVATO withMe Savings Program
2250 Perimeter Park Drive, Suite 300
Morrisville, NC 27560

You will receive your rebate check in about three weeks.

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

Clear Form Print Form

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Pharmacy Benefit Rebate Form

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2. You must complete the information below and sign the form.
3. Include a copy of the pharmacy receipt. Valid receipt will include your name, medication (name, billing code, and NDC#), date, and amount paid for your SPRAVATO® medication.

   If your receipt includes a prescription number and does not include SPRAVATO® medication name, also include a copy of your prescription label from the medication carton.
4. Submit this signed form by fax or mail along with your pharmacy receipt and, if required, prescription label from medication carton (see below for details). Eligible patients will receive a rebate check in about three weeks.

If you are submitting an **Explanation of Benefits (EOB)** and want to receive a rebate check, only complete the Medical Benefit Rebate Form on the previous page.

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*Name _____ *Date of Birth (mm/dd/yyyy) _____ Sex ☐ Male ☐ Female

E-mail _____ *Phone _____

*Address _____ *City _____ *State _____ *ZIP _____

*11-digit Savings Program medical claims member # found on the front of the Savings Program card

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*Patient Signature _____ *Date _____

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