Referral Checklist

Spravato™ is being added to more insurance formularies, but that does not guarantee coverage. We are working with JANSSEN® CONNECT® to make treatments as affordable as possible. Complete the list below to determine your coverage details.

Please note that this investigation is for coverage of Spravato™ only and does not include the cost of administration and observation. We are in network with several commercial insurance plans, but coverage of Spravato™ does not guarantee coverage of services.

Referrals will only include the temporary administration and management of Spravato™. Patients should already have a relationship established with a psychiatrist to be considered for treatment and are expected to maintain this relationship during and post-treatment.

****Once completed, Fax all necessary items from the checklist to (502)371-5451****

_____ Janssen CarePath Benefits Investigation Form
_____ REMS Patient Enrollment Form
_____ Referral letter from Primary Psychiatrist
_____ 3 most recent notes from your primary psychiatrist and Initial Psychiatric Evaluation
_____ Patient Health Questionnaire-9
_____ Documentation indicating initiation of 2 antidepressants from different classes that were used at the same time providing inadequate response. They do not need to have been started at the same time, but they should have been used together at some point for more than 8 weeks.

For reference, listed below are some classes of antidepressants and commonly used examples.

**SSRIs:** Fluoxetine (Prozac), Sertraline (Zoloft), Paroxetine (Paxil), Escitalopram (Lexapro), Fluvoxamine (Luvox), Citalopram (Celexa), Volazodone (Viibrid), Vortioxetine (Brintellix)

**SNRI’s:** desvenlafaxine (Pristiq), duloxetine (Cymbalta), venlafaxine (Effexor), venlafaxine XR (Effexor XR), and levomilnacipran (Fetzima)

**TCA’s:** Amitriptyline, Desipramine (Norpramin), Doxepin, Imipramine (Tofranil), Nortriptyline (Pamelor), Protriptyline (Vivactil), Trimipramine (Surmontil)

**Aminoketones:** Bupropion(Wellbutrin)

**Tetracyclic:** Mirtazapine

If you do not fax this first to us, it may get lost with another provider. Therefore, please fax it directly to us at (502)371-5451.
1. 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 ___________
Patient Phone _________________________________
Email _________________________________________
Caregiver _____________________________________
(A caregiver/contact is someone who can be contacted in place of the patient.)
Relationship to Patient _________________________ Caregiver Phone ______________________
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.

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

☐ Please see attached insurance card(s).

Primary Medical Insurance

Primary Insurance Carrier __________________________________ Phone ______________________
Cardholder Name (First, MI, Last) __________________________ Policy # ______________ Group # ______________

Secondary Medical Insurance

Secondary Insurance Carrier ____________________________ Phone ______________________
Cardholder Name (First, MI, Last) __________________________ Policy # ______________ Group # ______________

Prescription Drug Insurance

Prescription Drug Insurer ____________________________ Card BIN # __________ Phone ______________________
Cardholder Name (First, MI, Last) __________________________ Policy # ______________ Group # ______________

Please see the full Prescribing Information, including Boxed WARNING and Medication Guide, for SPRAVATO™. Provide the Medication Guide to your patients and encourage discussion.
3. Provider Information (Required)

☐ I am the Referring Physician  ☑ I am the Prescribing & Treating Physician

Provider Name (First, Last): Eric Lydon, MD  Specialty (optional): Psychiatry

Site Name: Sensible Psychiatric Services  Site Contact: Lisa Dischinger

Address: 4010 Dupont Circle Suite 300

City: Louisville  State: KY  ZIP: 40207

Email: info@sensiblepsych.mygbiz.com

NPI #: 1609873579  DEA #: BL8538312  State License #: 39958  Tax ID #: 204002755

Phone: 502-894-6066  Fax: 502-371-5451

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.

4. Product Acquisition Plan

Healthcare Setting or Pharmacy must be Risk Evaluation and Mitigation Strategy (REMS) certified prior to ordering and/or dispensing SPRAVATO™.

☐ Medical Buy & Bill  ☐ Undecided

☐ REMS-certified Pharmacy Name: Genoa Pharmacy

Address: 2225 West Broadway Street

City: Louisville  State: KY  ZIP: 40211

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 above.

Location Information

☐ Inpatient  ☐ Hospital Outpatient  ☐ Outpatient Clinic  ☑ Private Practice  ☐ Other____________

Prescriber Name (First, Last): Eric Lydon, MD  Specialty (optional): Psychiatry

Practice Name: Sensible Psychiatric Services

Address: 4010 Dupont Circle, Ste 300

City: Louisville  State: KY  ZIP: 40207

Phone: (502) 894-6066  Fax: (502) 371-5451

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.

Please see the full Prescribing Information, including Boxed WARNING and Medication Guide, for SPRAVATO™. Provide the Medication Guide to your patients and encourage discussion.
6. 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™

Dose Strengths to Investigate:  □ 84 mg  □ 56 mg

Concomitant Oral Antidepressant: _______________________________________________

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

□ Celexa® (citalopram)  □ Pexeva® (paroxetine mesylate)  □ Cymbalta® (duloxetine)  □ Fetzima® (levomilnacipran)
□ Lexapro® (escitalopram) □ Prozac® (fluoxetine)  □ Effexor® (venlafaxine)  □ Khedezla® (desvenlafaxine succinate)
□ Paxil® (paroxetine) □ Zoloft® (sertraline)  □ Effexor XR® (venlafaxine XR) □ Pristiq® (desvenlafaxine)
□ Other: _________________________________________________________________

□ 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.

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

7. 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 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.

Third-party trademarks used herein are trademarks of their respective owners.

Please see the full Prescribing Information, including Boxed WARNING and Medication Guide, for SPRAVATO™. Provide the Medication Guide to your patients and encourage discussion.
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.
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.
SPRAVATO™ is available only through the SPRAVATO™ REMS, a restricted distribution program. Only healthcare settings, pharmacies, and patients enrolled in the program can prescribe, dispense, and receive SPRAVATO™. Your healthcare provider will help you complete this form and provide you with a copy.

Prescribers and patients: Please complete this form online at www.SPRAVATOrems.com or, once completed, fax it to the REMS at 1-877-778-0091

* Indicates Required Field

### Healthcare Setting Information

**Healthcare Setting Name**: Sensible Psychiatric Services  
**Healthcare Setting DEA#**: BL8538312

<table>
<thead>
<tr>
<th>Address 1</th>
<th>Address 2</th>
<th>City</th>
<th>State</th>
<th>ZIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>4010 Dupont Circle</td>
<td>Suite 300</td>
<td>Louisville</td>
<td>KY</td>
<td>40207</td>
</tr>
</tbody>
</table>

**Phone**: 502-894-6066  
**Fax**: 502-371-5451

### Prescribing Physician

**First Name**: Eric  
**Last Name**: Lydon

**Credentials**:  
- MD
- DO
- NP
- PA
- Other

**Specialty**: Psychiatry  
**Prescriber DEA#**: BL8538312

**Phone**: 502-894-6066  
**Fax**: 502-371-5451  
**Email**: lisa@sensiblepsych.mygbiz.com

### Receiving Physician – if different than Prescribing Physician

**First Name**:  
**Last Name**:  
**Phone**: 

### Relevant Clinical Information

Has the patient previously been treated with ketamine for treatment-resistant depression, pain syndromes or any other condition?  
- Yes  
- No

If YES, list all pre-existing conditions treated with ketamine:

List all pre-existing medical and psychiatric conditions:

List concomitant medications (e.g., adjunctive depression medications, sedative hypnotics, psychostimulants, monoamine oxidase inhibitors (MAOIs))
This section is to be completed by the Patient

### Patient Information

<table>
<thead>
<tr>
<th>First Name*</th>
<th>MI</th>
<th>Last Name*</th>
<th>Birthdate*: (MM/DD/YYYY)</th>
<th>Sex*: M ☐ F ☐ Other</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Email*:</th>
<th>Phone Number*:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Email is required for online enrollment only)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address 1*:</th>
<th>Address 2*</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>City*:</th>
<th>State*:</th>
<th>ZIP*:</th>
</tr>
</thead>
</table>

### Patient Agreement

By signing this form, I understand and acknowledge that:

**Before my treatment begins, I will:**
- Enroll in the SPRAVATO™ REMS by completing this Patient Enrollment Form with my healthcare provider. Enrollment information will be provided to the REMS.
- Agree to receive counseling on the risks and the need for monitoring for resolution of sedation and dissociation, and for any changes in my vital signs.

**During treatment I will:**
- Use the SPRAVATO™ nasal spray myself under the direct observation of a healthcare provider.
- Be observed at the healthcare setting where I get SPRAVATO™ for at least 2 hours after each treatment until the healthcare provider determines I am ready to leave the healthcare setting.

*I understand:*  
- Sedation and dissociation can result from treatment with SPRAVATO™ and I must stay after each treatment. Until these effects resolve, I may feel:  
  - sleepy and/or  
  - disconnected from myself, my thoughts, feelings and things around me.
- I should make arrangements to safely leave the healthcare setting and get home.
- I should not drive or use heavy machinery for the rest of the day on which I receive SPRAVATO™.
- I should contact my doctor or inform him/her at my next visit if I believe I have a side effect or reaction from SPRAVATO™.
- In order to receive SPRAVATO™, I am required to be enrolled in the REMS, and my information will be stored in a database of all patients who receive SPRAVATO™ in the United States.
- Janssen Pharmaceuticals, Inc. and its agents, including trusted vendors, may contact me via phone, mail, fax, or email to support administration of the REMS.
- Janssen Pharmaceuticals, Inc. and its agents, including trusted vendors, may use, disclose, and share my personal health information for the purpose of the operations of the REMS, including enrolling me into the REMS and administering the REMS, coordinating the dispensing of SPRAVATO™, and releasing and disclosing my personal health information to the Food and Drug Administration (FDA), as necessary, and as otherwise required by law.

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Patient Signature*:</th>
<th>Date*:</th>
</tr>
</thead>
</table>

Healthcare providers should report suspected adverse events or product quality complaints associated with SPRAVATO™ to Janssen at 1-800-JANSSEN or the FDA at 1-800-FDA-1088 or online at www.fda.gov/medwatch.
PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: ____________________________________________ DATE: __________________________

Over the last 2 weeks, how often have you been bothered by any of the following problems? (use “✓” to indicate your answer)

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead, or of hurting yourself</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

(add columns + + TOTAL: ____________________________)

(Hospitaal care professional: For interpretation of TOTAL, please refer to accompanying scoring card).

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

<table>
<thead>
<tr>
<th>Difficulty Level</th>
<th>___________</th>
<th>___________</th>
<th>___________</th>
<th>___________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not difficult at all</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Somewhat difficult</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very difficult</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extremely difficult</td>
<td></td>
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</table>

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