HEAL PSYCHIATRIC SERVICES INC.
FARZANA AMIN M.D.
ADULT/CHILD AND ADOLESCENT PSYCHIATRIST
THE KETAMINE CLINIC TRAINING CENTER CERTIFIED
ABPN CERTIFIED IN ADULT /CHILD AND ADOLESCENT PSYCHIATRY

1710 S. AMPHLETT BLVD, SUITE 250
SAN MATEO, CA 94402
PHONE: 650-273-4082. FAX: 650-275-7559
WEBSITE:: www.healpsych.com

SPRAVATO Evaluation Packet

Please fill out the following information and return it to our office at least 24 hours prior to your appointment. If at any point you have questions, concerns or feel overwhelmed, please call our office and we will be happy to assist you.

Initial Assessment

This assessment is a two-part process that involves a review of your medical history and then a second visit for your initial treatment. Your first appointment will last about an hour. The initial assessment, or consultation, will be used to evaluate the appropriateness of Spravato/esketamine in treating your depression. ***Dr Farzana Amin MD*** your Spravato prescribing psychiatrist, will use the assessment to determine a diagnosis and the risks and benefits of Spravato compared to other available treatments for your diagnosis.

The doctor will also want details about previous treatment for your depression including counseling history, names of medications and maximum dosage, duration of treatment, and reasons treatment was discontinued, such as lack of benefit or side effects. You should be prepared to complete formal medical history evaluations and sign consent forms.

There is also a chance that ***Dr Farzana Amin MD*** will request a physical examination from your primary care physician. This is not always the case, though, and will vary from patient to patient. If a physical examination is requested, it will most likely be used to carefully screen patients for the presence of medical conditions that are contraindicated with Spravato.

At the end of the assessment, ***Dr Farzana Amin MD*** will decide if you are a candidate for Spravato. If Spravato is right for you, she will create a treatment plan for you. Your next appointment will be your first treatment

Your first evaluation will be about 1 hours long. with Dr Amin, She will go over your medical history making sure you qualify treatment with Spravato. Make sure to review all the information in the packet, and email them back to us at **least 24 hours prior to your scheduled appointment.** If your information is not received 24 hours prior to your appointment, your appointment may need to be rescheduled. If at any point you have questions, concerns, or feel overwhelmed, please do not hesitate to contact our office. The paperwork can be completed on your computer or printed, filled, and scanned. Also, please send us a copy of a **valid photo ID** and a photo of the front and back of your **insurance card** (primary and secondary) so that we are able to verify your benefits and co-payments prior to your appointment time. We will be able to begin working on the prior authorization for Spravato as soon as we receive this information

Typical Treatment Schedule

- Month 1: Two treatments per week
- Month 2: One treatment per week
- Month 3+: Continue weekly treatment Or Treatment once every 2 weeks

Office Policies

Contacting Us

Always remember: if you have a potentially life-threatening emergency and need help **IMMEDIATELY, CALL 911 or GO TO AN EMERGENCY ROOM.** You can contact us once the situation is stabilized.

For general questions or concerns you can call our office during hours listed above and speak to a staff member. Be prepared to give a detailed message to the staff member. They will consult with your physician and will call you back. If you chose to leave a detailed voicemail, please be aware that calls are returned within 24 business hours.

If you call after the office is closed you can leave a message and we will call you back on the next business day or you can also send us an e-mail to appointments4heal@mdofficemail.com and expect an answer within 24-hours.

We will try our best to get back to you as soon as we can, but remember that urgent matters are handled first. If you have an urgent matter that **can't wait until the next business day**, please email appointments4heal@mdofficemail.com to get a call back.

Office Hours

Our Front Desk and phone lines are open from 9:00am to 5:00pm Monday through Thursday .

Spravato Treatment Hours

The office is open for Spravato treatments from 9:00am -5:00pm on Monday-Thursday. If these times are not convenient for you, please contact our office for further discussion about possible options.

Appointments

All appointments need to be confirmed within twenty-four (24) business hours of the time scheduled. If your appointment is not confirmed, it is subject to being canceled and you will be charged the No Show or the Late Cancellation fee. It is your responsibility to come to your appointments on the correct date and time.

If you need to cancel an appointment you will need to do it with at least twenty-four (24) business hours' notice by calling or emailing our office or you will be charged the Late Cancellation fee. Late cancellation fees are as follows: $100 for Follow up appointments, $200 for New Patient appointments.

Please be aware that we will need to obtain a CC on file to hold your appointment.

Electronic Communication Authorization

Heal Psychiatric Services Inc. may communicate with me using electronic (Non-HIPPA compliant) communications including email, text messages, and voicemail. I may be contacted using the numbers or addresses that I have provided to Heal Psychiatric Services Inc. or that I have used to initiate contact with Heal Psychiatric Services Inc. These communications may include appointment information, protected health information and confidential information. I understand that these electronic communications are not encrypted. We use reasonable means to ensure security of communication with these methods, however we can not guarantee the security of non-HIPPA compliant methods.

I Authorize Electronic Communication

I DO NOT Authorize Electronic Communication

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Card Holder Authorization for Credit Card Charges

Patient Information

Name of Patient: ____

Credit Card Information

First Name (as it appears on credit card): ____

Last Name (as it appears on credit card): ____

Relationship to Patient: ____

Credit Card Type ❑ **AmEx** ❑ **Discover** ❑ **MC** ❑ **Visa**

Credit Card Number: _________-_________-_________-_________

Expiration Date: ___________________ **CCV Code:** ___________

Credit Card Billing Address

Street/PO Box: ____

City: ____

State/Zipcode: ____

Billing Phone: ____

Acknowledgement

I authorize Dr. Farzana Amin M.D. to charge this credit/debit/HAS debit card for any and/or all co-payments, patient responsibility portions of my insurance explanations of benefits (if applicable), fee for the completion of any forms and/or letters I request, lost prescriptions, prescription refills, and missed/no-show or late appointment fees.

I certify that I am an authorized signer on the card provided and that the credit card number provided and signature below are the same as those on file with the credit card issuer.

____ ____________________

Cardholder's Signature Date

____

Printed Employee Name

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This authorization is valid for one year from the date below or ___________, whichever is earlier. I may cancel this authorization by signing, dating, and writing "CANCEL" on this original form or by sending a written, signed and dated request to the doctor above indicating my desire to cancel. I understand that once my information has been released, the recipient might re-disclose it, my doctor has no control over it and privacy laws may no longer protect it. The purpose of this authorization is to improve the quality of my mental health evaluation or treatment.

____
Patients Name

____
Patients Signature

______________________________ Date:--
Guardian's Signature (if patient is a minor)

Patient Name:		**DOB:**	**Initial each specific consent to release**
Family Members or Significant Others	Name/Relationship Name/Relationship Name/Relationship		☐ Yes ☐ No ______ Initial
Mental Health Professionals	Psychiatrist Phone Therapist Phone	**Purpose:** • To facilitate understanding and support in treatment. • To aid in diagnosis and continuity of care.	☐ Yes ☐ No ______ Initial
Primary Care Physician	Name/ Group Phone	**Type of information to be disclosed:**	☐ Yes ☐ No ______ Initial
Pharmacy		• All medical records ☐ • Progress Notes ☐ • Labs ☐ • Medications ☐	☐ Yes ☐ No ______ Initial
Other Specialists	Name/ Group/ Phone Name/ Group/ Phone Name/ Group/ Phone	• Evaluations ☐ • Other: ______________ Text ______________	☐ Yes ☐ No ______ Initial
Referrals			☐ Yes ☐ No ______ Initial

PATIENT DEMOGRAPHICS

Last Name: First Name: Middle Name:

Address: City: State: Zip:

Home Phone: Cell Phone:

Social Security Number: DOB: Gender: M F

Marital Status: Ethnicity:

Employer Name:

Employer Address and Phone:

PRIMARY INSURANCE INFORMATION

Insurance Carrier: Policy ID: Group Number:

Policy Holder's Name: Group Name:

Policy Holder's DOB: Relationship to Patient:

Policy Holder's Social Sec Number:

Policy Holder's Employer:

Employer Address and Phone:

SECONDARY INSURANCE INFORMATION

Insurance Carrier: Policy ID: Group Number:

Policy Holder's Name: Group Name:

Policy Holder's DOB: Relationship to Patient:

Employer Address and Phone:

IF YOU HAVE A SECONDARY INSURANCE POLICY, IT IS YOUR RESPONSABILITY TO ADVISE THE STAFF WHICH IS THE PRIMARY AND WHICH IS THE SECONDARY INSURER. FAILURE TO DO SO MAY CAUSE SUBMISSION TO THE INCORRECT INSURANCE COMPANY. INSURERS HAVE TWO (2) YEARS TO RECOUP MONIES THAT HAVE BEEN DISPENSED IN ERROR, AND ONCE THE NOTICE OF RECOUPMENT IS RECEIVED, IT IS LIKELY THAT THE TIMELY FILING LIMIT FOR THE CORRECT INSURER HAS PASSED. IF THAT SHOULD HAPPEN, IT BECOMES THE PATIENT'S RESPONSABILITY FOR THE CHARGES INCURRED. PATIENT'S INITIALS:

EMERGENCY CONTACT INFORMATION

Emergency Name: Relationship:

Emergency Address: City: State: Zip:

Emergency Phone #1: Emergency Phone #2:

FINANCIALLY RESPONSIBLE PARTY INFORMATION

☐ Same as patient demographics

Last Name: First Name: Middle Name:

Address: City: State: Zip:

Relationship to Patient:

Home Phone: Cell Phone:

Social Security Number: DOB: Gender: M F

Employer Address and Phone:

DO YOU HAVE A HEALTH CARE SURROGATE OR A LEGAL GUARDIAN? YES NO

Surrogate/Guardian Name: Relationship:

Surrogate/Guardian Address: City: State: Zip:

Surrogate/Guardian Phone #1: Surrogate/Guardian Phone #2:

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New Patient Medical History Form

Please complete all information on this form and email it to appointments4heal@mdofficemail.com prior to your first visit. Please get it to our office **24 hours before** your scheduled appointment

Name____

Email: ____

What are the problem(s) for which you are seeking help?

1. ____
2. ____
3. ____

What are your treatment goals?

____
____

Pharmacy Name & Location ______________________________ Phone #__________________

Secondary Pharmacy ___________________________________ Phone# __________________

Medical History

Do you have any known allergies? ( ) Yes ( ) No

If yes please explain:

____
____

Do you have any adverse drug reactions? ( ) Yes ( ) No

If yes please explain:

____
____

What are your other **non-psychiatric** medical diagnoses? (ie. Asthma, diabetes, high blood pressure etc.)

____
____
____
____
____
____

List ALL medications you are currently taking (**non-psychiatric**) including dosage and how often you take them. Please include everything you take from vitamins, OTC medications, and prescribed medications

Medication Name	Diagnosis	Daily Dose	How Often

Do you take your medication as prescribed? ( ) Yes ( ) No

List any non-psychiatric hospitalizations including year. (ie. Severe flu, stomach pain etc) If none write N/A

List any surgeries including type of surgery, location, and year

Do you exercise regularly? ( ) Yes ( ) No
How much alcohol do you consume? ______
How many caffeinated beverages do you drink a day? Coffee______ Soda______ Other______
Do you use recreational drugs ( ) Yes ( ) No If yes, which ones______
Do you have trouble sleeping?( ) None ( ) Yes, falling asleep ( )Yes, staying asleep ( ) Both
On average, how many hours of sleep do you get per night? ______
Are there any sources of stress in your life? ( ) Yes ( ) No
If yes, explain:

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Do you use tobacco products? (   ) Yes   (   ) No

If yes, what form and how often:

____

Do you suffer from chronic pain?   (   ) Yes   (   ) No

If yes, include location, severity and timing of pain:

____

____

____

Name of Primary care Provider: ___________________________________Last Seen: _____________

Any other non-psychiatric providers currently being seen:

____

____

____

____

____

____

List any recent diagnostic testing (labs or imaging). Include type date and location where testing was done

____

____

____

____

____

Have you received the COVID-19 Vaccine?   Yes   No

If you have: Date of 1st Dose: _____________   Date of 2nd Dose:________________

If you have not received it, do you plan on getting it?   Yes   No

<u>Past Psychiatric History</u>

List any previous psychiatrists you have seen in the **last 5 years**, including years/dates of treatment, and treatment outcome.

____

____

____

____

____

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____

List any previous therapists you have seen in the **last 5 years**, including years/dates of treatment and treatment outcome

____

____

____

____

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List any psychiatric disorders you have been diagnosed with including: the age you began treatment and which doctor gave you the diagnosis:

____
____
____
____
____

List any psychiatric hospitalizations including the provider name, dates, reason and outcome

Provider Name	Dates	Reason	Outcome

In the past, have you tried electroconvulsion therapy (ECT)? ( ) Yes ( ) No
If you answered yes, please complete the following questions:

Name of Facility ____________________________________
Dates: ____
Reason:____
Number of Sessions__________________________________
Outcome:_______________________________________

In the past have you tried Ketamine or Esketamine treatment? ( ) Yes ( ) No
If you answered yes, please complete the following questions:

Name of Facility ____________________________________
Dates: ____
Reason:____
Number of Sessions__________________________________
Outcome:_______________________________________

List any previous psychotherapy treatment including the provider name, dates, reason and outcome

Provider Name	Dates	Reason	Outcome

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List any Outpatient treatments including when, by whom and nature of treatment. Please also describe the outcome of the treatment

Reason	Dates/ Length	Provider Name	Outcome

In the past have you been suicidal or self-injurious? ( ) Yes ( ) No
In the past, have you ever made a suicidal attempt? ( ) Yes ( ) No
If yes, please indicate the year(s) it occurred

____

____

In the past, have you been assaultive towards someone else? ( ) Yes ( ) No
Do you have a history of substance abuse? ( ) Yes ( ) No
If yes, include what substance, when, how long, and date of last use:

____

____

____

____

Have you done a genetic testing for psychotropic medications (ie. GeneSight) ( ) Yes ( ) No
If yes, please send the office a copy of your results prior to your appointment.
If yes, what is the date of testing: ______________________________

List any psychological/neuropsychological testing you have completed including the name of the provider, year, and reason for testing. **If you have, please send the office a copy of your results prior to your appointment.**

Name of Provider	Year	Reason

List any pharmacies you have used in the last **5 years.** Please include the name , location and phone number of the pharmacy.

Pharmacy Name	Location	Phone Number

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Past Psychiatric Medications: If you have ever taken any of the following medications, please indicate the dates, dosage, and how helpful they were (if you can't remember all the details, just write in what you do remember). When describing the reason stopped please indicate whether it was ineffective or if you experience side effects and if so, what side effects.

Antidepressants	Dates	Dosage	Reason Stopped
Prozac (fluoxetine)			
Zoloft (sertraline)			
Luvox (fluvoxamine)			
Paxil (paroxetine)			
Celexa (citalopram)			
Lexapro (escitalopram)			
Effexor (venlafaxine)			
Cymbalta (duloxetine)			
Wellbutrin (bupropion)			
Remeron (mirtazapine)			
Serzone (nefazodone)			
Anafranil (clomipramine)			
Pamelor (nortrptyline)			
Tofranil (imipramine)			
Elavil (amitriptyline)			
Other			

Mood Stabilizers	Dates	Dosage	Reason Stopped
Tegretol (carbamazepine)			
Lithium			
Depakote (valproate)			
Lamictal (lamotrigine)			
Tegretol (carbamazepine)			
Topamax (topiramate)			
Other			

Typical Antiphsychotics	Dates	Dosage	Reason Stopped
Haldol (haloperidol)			
Loxitane (loxapine)			
Mellaril (thioridazine)			
Moban (molindone)			
Navane (thiothixene)			
Prolixin (fluphenazine)			
Serentil (mesoridazine)			
Stelazine (trifluoperazine)			
Thorazine (chlorpromazine)			
Trilafon (perphenazine)			

Past Psychiatric medications (continued)

Atypical Antipsychotics	Dates	Dosage	Reason Stopped
Abilify (aripiprazole)			
Clozaril (clozapine)			
Risperdal (risperidone)			
Seroquel (quetiapine)			
Zyprexa (olanzepine)			
Geodon (ziprasidone)			
Rexulti (Brexpiprazole)			
Vraylar (Cariprazine)			
Other			

Sedative/Hypnotics	Dates	Dosage	Reason Stopped
Ambien (zolpidem)			
Sonata (zaleplon)			
Rozerem (ramelteon)			
Restoril (temazepam)			
Desyrel (trazodone)			
Other			

ADHD Medications	Dates	Dosage	Reason Stopped
Adderall (amphetamine)			
Concerta (methylphenidate)			
Ritalin (methylphenidate)			
Strattera (atomoxetine)			
Vyvanse (Lisdexamfetamine)			
Other			

Antianxiety medications	Dates	Dosage	Reason Stopped
Xanax (alprazolam)			
Ativan (lorazepam)			
Klonopin (clonazepam)			
Valium (diazepam)			
Tranxene (clorazepate)			
Buspar (buspirone)			
Centrax (prazepam)			
Librium (chlordiazepoxide)			
Inderal (propranolol)			
Serax (oxazepam)			
Tenormin (atenolol)			
Hydroxyzine			
Other			

Has anyone in your family been diagnosed with a behavioral health disorder? ( ) Yes ( ) No

If yes, explain which family member?

____

____

____

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Social History

Where were you born:______________________________

Who were you primarily raised by:______________________________

What is your birth order and how many siblings do you have? ______________________________

How would you describe the quality of your childhood? ______________________________

Were there any sources of family stressors growing up? ______________________________

How is the relationship quality with your family member?

____

____

Education History

Have you received your high school diploma? ( ) Yes ( ) No

Have you received a GED certificate? ( ) Yes ( ) No

Have you attended college ( ) Yes ( ) No

Have you graduated from college ( ) Yes ( ) No

If so, please list area of study ______________________________

Employment History

Occupation: ______________________________

Length of Current position: ______________________________

How would you describe your work quality?______________________________

Relationship/ Marriage

Are you currently married? ( ) Yes ( ) No

Length of current marriage? ______________ Quality of current marriage? ______________

How many times have you been married? ______________

Children Information

Do you have any children? ( ) Yes ( ) No If yes, how many ______________

Are they from your current marriage or previous marriage? ______________________________

How is your relationship with your child/ children ______________________________

Have you ever been in the Military? ( ) Yes ( ) No

If yes, include what branch, type of discharge (if applicable), and any trauma as a result:

____

____

Have you ever been arrested? ( ) Yes ( ) No

If yes, please explain:

____

____

____

Who is currently in you support system?

____

____

FOR IN OFFICE USE ONLY

Reviewed by: ______________________________ Date: ______________________________

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Janssen Patient Support Program
Patient Authorization Form

Patients should read the Patient Authorization, check the desired permission boxes, sign, and return both pages of the Form to the Janssen Patient Support Program.

- Completed Form may be faxed to 844-577-7282 or mailed to Partner withMe, 680 Century Point, Lake Mary, FL 32746
- Patients may also read, eSign, and submit a digital version of this form at **SpravatowithMePatientAuth.com**

Patient Name ______________________ **Email Address** ______________________

I give permission for each of my "Healthcare Providers" (eg, my physicians, pharmacists, specialty pharmacies, other healthcare providers, and their staff) and "Insurers" (eg, my health insurance plans) to share my Protected Health Information as described on this Form.

My "Protected Health Information" includes any and all information related to my medical condition, treatment, prescriptions, and health insurance coverage.

The following person(s) or class of person(s) are given permission to receive and use my Protected Health Information (collectively "Janssen"):

- Johnson & Johnson Health Care Systems Inc., its affiliated companies, agents, and representatives
- Providers of other sources of funding, including foundations and co-pay assistance providers
- Service providers for the patient support programs, including subcontractors or Healthcare Providers helping Janssen run the programs
- Service providers maintaining, transmitting, de-identifying, aggregating, or analyzing data from Janssen patient support programs

Also, I give permission to Janssen to receive, use, and share my Protected Health Information in order to:

- see if I qualify for, sign me up for, contact me about, and provide services relating to Janssen patient support programs, including in-home services
- manage the Janssen patient support programs
- give me educational and adherence materials, information, and resources related to my Janssen medication in connection with Janssen patient support programs
- communicate with my Healthcare Providers regarding access to, reimbursement for and fulfillment of my Janssen medication, and to tell my Healthcare Provider that I am participating in Janssen patient support programs
- verify, assist with, and coordinate my coverage for my Janssen medication with my Insurers and Healthcare Providers
- coordinate prescription or treatment location and associated scheduling
- conduct analysis to help Janssen evaluate, create, and improve its products, services, and customer support for patients prescribed Janssen medications
- share and give access to information created by the Janssen patient support programs that may be useful for my care

I understand that my Protected Health Information may be shared by Janssen for the uses written in this Form to:

- My Insurers
- My Healthcare Providers
- Any of the persons given permission to receive and use my Protected Health Information as mentioned above
- Any individual I give permission as an additional contact

Janssen and the other data recipients listed on this Form may share information about me as permitted on this Form or if any information that specifically identifies me is removed. I understand that Janssen will use reasonable efforts to keep my information private but once my Protected Health Information is disclosed as allowed on this Form, it may no longer be protected by federal privacy laws.

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Clear Form Print Form

Janssen Patient Support Program
Patient Authorization Form

I understand that I am not required to sign this Form. My choice about whether to sign will not change how my Healthcare Providers or Insurers treat me. If I do not sign this Form, or cancel or remove my permission later, I understand I will not be able to participate or receive assistance from Janssen's patient support programs.

I understand that pharmacies that dispense and ship my medication and service providers for the patient support programs may be paid by Janssen for their services and data. This may include payment for sharing Protected Health Information and other data in connection with these programs, as allowed on this Form.

This Form will remain in effect 10 years from the date of signature, except where state law requires a shorter time, or until I am no longer participating in any Janssen patient support programs. Information collected before that date may continue to be used for the purposes set forth in this Form.

I understand that I may cancel the permissions given by this Form at any time by letting Janssen know in writing at: Partner withMe, 680 Century Point, Lake Mary, FL 32746.

I can also cancel my permission by letting my Healthcare Providers and Insurers know in writing that I do not want them to share any information with Janssen.

I further understand that if I cancel my permission it will not affect how Janssen uses and shares my Protected Health Information received by Janssen prior to my cancellation.

I understand I may request a copy of this Form.

Permission for communications outside of Janssen patient support programs:

☐ Yes, I would like to receive communications relating to my Janssen medication.

☐ Yes, I would like to receive communications relating to other Janssen products and services.

For privacy rights and choices specific to California residents, please see Janssen's California privacy notice available at **https://www.janssen.com/us/privacy-policy#california**

Permission for text communications:

☐ Yes, I would like to receive text messages. By selecting this option, I agree to receive text messages as allowed by this Form to the cell phone number provided below. Message and data rates may apply. Message frequency varies. I understand I am not required to provide my permission to receive text messages to participate in the Janssen patient support programs or to receive any other communications I have selected.

Cell phone number: ______________________________

Patient name (print): ______________________________

Patient sign here: ______________________________ **Date:** __________

If the patient cannot sign, patient's legally authorized representative must sign below:

By: ____________________ **Print Name:** ____________________ **Date:** __________

(Signature of person legally authorized to sign for patient)

Describe relationship to patient and authority to make medical decisions for patient:

____

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Clear Form Print Form

Spravato® (esketamine) CIII nasal spray

SPRAVATO® REMS

Patient Enrollment Form - Outpatient Use Only

janssen PHARMACEUTICAL COMPANIES OF Johnson & Johnson

This section is to be completed by the Patient

Your healthcare provider will help you complete this form and provide you with a copy.

** Indicates required field*

Patient Information

First Name*:	MI:	Last Name*:	Birthdate*: (MM/DD/YYYY):	Sex*: ☐ Male ☐ Female ☐ Other

Email*: (Email is required for online enrollment only)	Phone Number*:
Address 1*:	Address 2:

City*:	State*:	ZIP*:

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 submitted to the SPRAVATO® REMS.
- Receive counseling on safety risks and the need for monitoring to observe for resolution of sedation and dissociation, and for any changes in vital signs.

During treatment, and after administration 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 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® as an outpatient, I am required to be enrolled in the REMS, and my information will be stored in a database of all outpatients who receive SPRAVATO® in the United States.
- Janssen Pharmaceuticals, Inc. and its agents, including trusted vendors, may contact me or my prescriber 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.

Patient Name (please print):	
Patient Signature*:	**Date*:**

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