Spravato withMe

Spravato® (esketamine) C III
28 mg nasal spray

SPRAVATO withMe Savings Program
Patient Assignment of Benefits

1. **OPTIONAL:** This form is optional. Signing this form is not required for a patient to receive medical treatment, to start or stay on therapy, or to be enrolled in SPRAVATO withMe.
2. **AUTHORIZATION:** By signing this form, the patient authorizes SPRAVATO withMe to issue payment directly to their provider for any reimbursement amounts attributable to the costs of SPRAVATO® administered in their provider's office. This form's authorization is not limited to one provider, but grants patient authorization for all of the patient's treatment providers who submit a rebate request to SPRAVATO withMe Savings Program.
3. **BENEFITS:** This form is limited to repayment of the costs of medication that are administered in the provider's office. It does not cover the cost of the office visit or your treatment's administration.
4. **INSTRUCTIONS:** Patient must read this form, complete all fields, sign, and return this form to their provider if the patient is in agreement with the assignment of the above benefits to all providers from whom the patient receives medical services related to SPRAVATO®. Providers should fax the completed form to SPRAVATO withMe at 844-584-1453, or mail to SPRAVATO withMe, 2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560.
5. **CANCELLATION:** Patient can, at any time, call SPRAVATO withMe and elect for the rebate check(s) (payment) to be sent directly to them.

Patient Information:

Patient Name: _____ Date of Birth (mm/dd/yyyy): _____

SPRAVATO withMe Savings Program Member #: _____
(from the front of your Savings Program card)

Patient Address: _____

City: _____ State: _____ ZIP Code: _____

Patient Authorization:

My signature on this Patient Assignment of Benefits Form confirms that I authorize that each of my SPRAVATO withMe Savings Program out-of-pocket payment(s) be sent on my behalf to all provider(s) for payment of my out-of-pocket SPRAVATO® medication cost(s). I also understand that I may, at any time, call SPRAVATO withMe and elect for the rebate check(s) to be sent directly to me.

Patient Signature: _____ 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 read the full Prescribing Information, including Boxed WARNINGS, and Medication Guide for SPRAVATO® and discuss any questions you may have with your healthcare provider.