Complete Ketamine
SOLUTIONS

Patient Information

Patient Name:_____ DOB:_____
Driver's License:_____ SSN:_____
Home Phone:_____ Sex:_____
Address:_____
City:_____State:_____Zip:_____
Cell:_____ Email:_____

Emergency Contact Information

Emergency Contact:_____
Home Phone:_____ Cell:_____
Address:_____
Relationship:_____ Work:_____
Emergency Contact:_____
Home Phone:_____ Cell:_____
Address:_____
Relationship:_____ Work:_____

Medical History

Current Medications:_____
Allergies:_____
Medical Doctor:_____
Address:_____
Phone Number:_____

I verify that the above information is factual and true to the best of my knowledge. I authorize the doctor to employ x-rays, photographs, anesthetics, medicines, surgeries, and other equipment or aids as he/she deems necessary in order to provide the proper patient care. I understand that payment is due at time of service.

_____ _____
Patient Signature Date

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I _____ am receiving Spravato treatments at Complete Ketamine Solutions, PLLC. These treatments require me to remain in the office for an entire two hour treatment period. I am aware and fully understand that a two hour office visit to Complete Ketamine Solutions carries with it a cost of $300 per visit. I also understand fully understand that I am personally and financially responsible for the full balance due for each office visit. I fully consent and agree to have The staff at Complete Ketamine Solutions bill my insurance company for services rendered. I am also aware and fully understand that I bear full financial responsibility for monies not received by Complete Ketamine Solutions from my insurance company for the amount specified above on a per visit basis. I also understand that failure to reimburse CKS monies owed on a 30 day net term could cause me to become ineligible for further treatment, be dismissed or discharged from the clinic and also could be sent to a third party for collection services. By signing this agreement, I _____ Agree to reimburse Complete Ketamine Solutions, PLLC any monies not received from my insurance company in the amount of $300; that I've agreed to pay per office visit.

_____ _____

Signature. Date

_____ _____

Witness. Date

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Permission to Use Ketamine as a Treatment for Depression

Ketamine is a drug that calms and relaxes the body. It is approved by the FDA for use in anesthesia and as a pain reliever during medical procedures. It generally does not impact your breathing. Ketamine's use for treatment of depression or other mental illnesses is off-label and has not been approved by the FDA.

Why Is Ketamine Being Recommended for Me?

Research has shown that ketamine may be helpful in the treatment of depression. When administered intravenously over a period of about 60 minutes (called an infusion), ketamine may help depression improve rather quickly, but it may last only a few days. A series of infusions is used so that the improvement lasts much longer. While the goal is improvement of depression, results cannot be guaranteed.

What Will Be Done?

I will be receiving ketamine by IV Infusion. This means an IV will be inserted into a vein of my hand or arm and fluid will be dripped into the vein over roughly 60 minutes. This fluid will contain a ketamine dose of 0.5 mg/ kg of my body weight. (By comparison, when ketamine is used for anesthesia, the dose is often much higher and is given via a rapid IV push, as opposed to a slow infusion over 60 minutes). After the treatment, I will need a bit of time to recover and may take some sips of fluid if I feel like doing so. I understand that I will be scheduled to receive 6 treatments over about two weeks as a treatment episode. Additional maintenance treatments may or may not be suggested, occurring about once a month or less frequently depending on how I respond to the infusions.

What Safety Precautions Must I Take?

- I may not eat or drink for 4 hours before each of the infusions.
- I may NOT drive a car, operate hazardous equipment, or engage in hazardous activities for 24 hours after each treatment, as reflexes may be slow or impaired. Another adult will need to drive me home.
- I should refrain from alcohol and other narcotic substances for 24 hours prior to and after treatment infusions.
- I must tell the clinic about all medications I am taking, especially narcotic pain relievers or barbiturates.
- In order to qualify to receive ketamine therapy, I will require medical clearance and must share with my ketamine provider the contact information for the doctor or doctors who are treating my depression or anxiety or other psychiatric symptoms.
- If I experience a side effect while I am at home, I should contact the Complete Ketamine Solutions, my primary care doctor, call 911 or go to my local emergency room.

What Are the Side Effects of Ketamine?

When Ketamine is used as an anesthetic agent the following are listed as side effects:

- fast, irregular or low heart beats
- increased or decreased blood pressure
- dreams that may seem real
- confusion
- irritation or excitement when waking up
- floating sensation ("out-of-body")
- breathing problems
- twitching, muscle jerks, and muscle tension
- increased saliva or thirst
- lack of appetite
- headaches
- metallic taste
- constipation
- blurry or double vision
- nausea or vomiting
- risk of drug addiction or dependence

Rare side effects of ketamine are:

- allergic reactions
- pain at site of injection
- increase in pressure inside the eye
- ulcerations and inflammation in the bladder
- Pancreatitis
- hallucinations
- euphoria
- involuntary eye movements
- low mood or suicidal thoughts

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Side effects of receiving an IV are:

- mild discomfort at the site of placement
- bruising
- bleeding
- dizziness
- fainting
- infection

Important Notices and Agreements:

- KETAMINE INFUSION THERAPY IS NOT A COMPREHENSIVE TREATMENT FOR DEPRESSION, ANXIETY OR ANY PSYCHIATRIC SYMPTOMS.
  Your ketamine infusions are meant to augment (add on to, not be used in place of) comprehensive psychiatric treatment. We advise you to be (and I agree to be) under the care of a qualified mental health professional (or an internal medicine or family physician with experience and skill in treating psychiatric illnesses) while receiving ketamine infusions, and for the duration of your psychiatric symptoms.

- SPECIAL NOTE ON SUICIDAL IDEATION
  Psychiatric illnesses (especially, depression) carry the risk of suicidal ideation (thoughts of ending one's life). Any such thoughts you may have now, at any time during the weeks of your ketamine infusions, or at any point in the future, which cannot immediately be addressed by visiting with a mental health professional should prompt you to seek emergency care at an ER or to call 911.

- Ketamine use during pregnancy is not generally recommended.

- Caution is highly recommended with ketamine use in patients under the age of 16.

My Consent for Ketamine Treatment is Voluntary:
My request for Complete Ketamine Solutions to conduct ketamine infusion treatments as described is entirely voluntary and I have not been offered any inducement to consent. I understand that I may refuse ketamine treatments and that my regular treatments for depression would continue. Any money I have deposited that has not been subject to fees by Complete Ketamine Solutions will be refunded to me if I choose not to proceed. I have been advised that I can seek a second opinion from another doctor before agreeing to have ketamine treatment and am choosing to proceed at this time with or without this second opinion. I also acknowledge and agree that ketamine infusions for the treatment of depression is not FDA approved at this time and is still considered experimental and that the results of my treatment with ketamine may be used to show the efficacy of ketamine treatment in depression but my personal health information would not be shared with outside parties without expressed written consent.

Complete Ketamine Solutions Infusion Clinic, in the hopes to mitigate the possible abuse of Ketamine outside of their facility, participates in random patient drug testing. I hereby agree to participate in random urine drug screening prior to any of my Ketamine infusions. I understand that if I am randomly chosen to perform a urine drug screen, and I refuse, I must discuss with Complete Ketamine Solutions Medical Director per their Policies and Procedures before I am allowed to proceed with treatment.

Statement of Person Giving Informed Consent

- I have read this consent form and understand the information contained in it.
- I have had the opportunity to ask questions about this procedure and consent and wish for Complete Ketamine Solutions and its staff to administer ketamine infusion treatment.

Signature of Patient or legally responsible party _____ Relationship to Patient _____ Date

Signature of Witness _____ Date

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The medical/psychiatric provider treating my symptoms of depression, anxiety, PTSD, and/or chronic pain is:

Name

Phone FAX

Address

Email

RELEASE OF MEDICAL INFORMATION

I herby authorize my ketamine provider to disclose my medical records, including any history of substance use or abuse, to the individual listed above, or appropriate personnel in his or her office. I further authorize the individual listed above to disclose my medical records, including any history of substance use or abuse, to my ketamine provider, or appropriate personnel in his or her office.
I also authorize my ketamine provider to discuss my care and share information for the purposed of monitoring, biling, quality control and other business purposes with Complete Ketamine Solutions who has agreed to HIPAA levels of security about my personal information.

Signature of Patient or legally responsible party Date

IN THE EVENT OF AN EMERGENCY

My Emergency Contact Is:

Name

Phone Fax

Address

Relationship

I herby authorize my ketamine provider to disclose my medical condition to the above person in the event of concern about my post procedure recovery or any emergency situation so that this person may assist me as needed.

Signature of Patient or legally responsible party Date

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Patient Instructions

Pre-Treatment:

1. No solid food or milk products for four (4) hours before your treatment time.
2. Food and beverages are not permitted during the infusion.
3. Please turn off all cell phones during treatment.
4. You may bring your own pillow and blanket for comfort during the infusion.
5. No reading or watching movies during treatment.
6. No narcotics on the day of treatment. Take your normal medications the morning of your treatment with a sip of water.
7. Please try to maintain a calm, quiet demeanor throughout the infusion in effort to remain relaxed and comfortable.

Post-Treatment:

1. No driving or operating heavy equipment for 24 hours after a treatment.
2. No alcohol consumption within 24 hours after completing the infusion.
3. Resume regular diet as tolerated. On rare occasions, some patients will experience nausea
4. Resume normal afternoon or evening medications.
5. Go to the emergency room if you experience chest pain, hives, shortness of breath, increasing weakness or swelling of your IV site with redness. It is normal to feel fatigue the day of treatment.

Janssen CarePath UPDATE 7.19 Benefits Investigation Form

Spravato™ (esketamine) C-III nasal spray

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 WARNINGS and Medication Guide, for SPRAVATO™. Provide the Medication Guide to your patients and encourage discussion.

Janssen CarePath

Benefits Investigation Form

Spravato™ (esketamine) CII nasal spray

3. Provider Information (Required)

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

Provider Name (First, Last) Clint Fletcher Specialty (optional) _____

Site Name Complete Ketamine Solutions Site Contact Ashley Wease | Clint Fletcher

Address 1916 Patterson St Ste 208

City Nashville State TN ZIP 37203

Email Completeketamine@gmail.com

NPI # 1215991656 DEA # MF4648258 State License # APN0000010793 Tax ID # 83-1603912

Phone (629) 203-7118 Fax (629) 203-7138

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 Midtown Express Pharmacy

Address 300 20th Ave N Unit 105 Address 2 _____

City Nashville State TN ZIP 37203

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) _____

Specialty (optional) _____

Practice Name _____

Address _____

City _____ State _____ ZIP _____

Phone _____ Fax _____

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 WARNINGS and Medication Guide, for SPRAVATO™. Provide the Medication Guide to your patients and encourage discussion.

Janssen CarePath

Benefits Investigation Form

Spravato™ (esketamine) CII nasal spray

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. ☐

Janssen CarePath

HIPAA Patient Authorization for Janssen CarePath

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.

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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 WARNINGS and Medication Guide for SPRAVATO™, and discuss any questions you have with your doctor.

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