

# INSTRUCTIONS:

This form is intended only for use by outpatient medical offices or clinics, **excluding emergency departments**. You must also submit the **Patient Enrollment Form** if this is the patient's first treatment session.

1. Monitor the patient for any signs of sedation, dissociation, or respiratory depression during the 2-hour monitoring period as a requirement of the REMS.
2. Complete all required fields on this form after **every** treatment session for **all outpatients** enrolled in the SPRAVATO® REMS.
3. Submit completed patient monitoring forms within **7 days** online at [www.SPRAVATOREMS.com](http://www.SPRAVATOREMS.com).

\* Indicates Required Field

Patient			
First Name*:	MI:	Last Name*:	Birthdate* (MM/DD/YYYY): Sex*: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other
Is this the patient's first treatment* <input type="checkbox"/> Yes <input type="checkbox"/> No			
If YES, is the patient enrolled*? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If NO is selected, please submit the Patient Enrollment Form at <a href="http://www.SpravatoREMS.com">www.SpravatoREMS.com</a> or by fax.			
Concomitant Medication			
Is the patient currently taking any of the following medication(s) that may cause sedation, dissociation, respiratory depression, or blood pressure changes (including but not limited to benzodiazepines, sedative hypnotics, opioids, psychostimulants)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, list medications here: _____			
Monitoring Healthcare Provider			
First Name*:		Last Name*:	
Telephone*:		Email*:	
Healthcare Setting Information (PRINT)			
Healthcare Setting Name*:			
Healthcare Setting Address 1*:		Healthcare Setting Address 2:	
City*:	State*:	ZIP*:	Healthcare Setting DEA Number*:
Patient Treatment Session Information (Administration and Monitoring)			
Treatment Date* (MM/DD/YYYY): _____			
Dose Administered*	<input type="checkbox"/> 56 mg <input type="checkbox"/> 84 mg <input type="checkbox"/> Other: _____		Lot Number*: _____
Treatment Duration* (Patient must be monitored for <u>at least</u> 2 hours)	Total treatment duration _____ minutes (from 1st device administration to completion of monitoring) If not monitored for at least 2 hours, provide reason why: _____		
<b>Monitoring of Vital Signs*:</b> Were vital signs in acceptable range prior to: Administration? <input type="checkbox"/> Yes <input type="checkbox"/> No Treatment session completion? <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Monitoring of Pulse Oximetry*:</b> Was pulse oximetry at an acceptable level prior to administration? <input type="checkbox"/> Yes <input type="checkbox"/> No During treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No At treatment session completion? <input type="checkbox"/> Yes <input type="checkbox"/> No If a Serious Adverse Event (SAE) occurred during the session, describe in the following section	
Serious Adverse Events of Interest			
For this SPRAVATO® REMS, a Serious Adverse Event (SAE) of interest is defined as any event involving <b>sedation, dissociation, respiratory depression, or hypertension</b> that results in death, hospitalization, disability/permanent damage, an important medical event+, or is life-threatening.			
Did the patient experience a SAE of interest as defined above?			
<input type="checkbox"/> Yes (describe in following section) <input type="checkbox"/> No			

\* Indicates Required Field

Patient Information (PRINT)			
First Name*:	MI:	Last Name*:	Birthdate* (MM/DD/YYYY): Sex*: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other
Monitoring Healthcare Provider			
First Name*:		Last Name*:	
Phone*:		Email:	
Treatment Date (MM/DD/YYYY):			
Serious Adverse Events of Interest – Additional Details (PRINT)			
<i>Janssen Pharmaceuticals, Inc., a Johnson &amp; Johnson Company Safety Department will follow up to obtain more information about events reported in this table. If needed, add additional pages to document SAEs.</i>			
Event Outcome (Check all that apply)*	Event Timing	Description of Serious Adverse Event of Interest (include relevant details such as clinical course, therapeutic interventions, comorbidities, prescription/nonprescription medications)	Event Resolution
The SAE resulted in one or more of the following outcomes: <input type="checkbox"/> Death <input type="checkbox"/> Life-threatening <input type="checkbox"/> Hospitalization <input type="checkbox"/> Disability/permanent damage <input type="checkbox"/> Important Medical Event	Date of Event (MM/DD/YYYY)	<input type="checkbox"/> Sedation <input type="checkbox"/> Dissociation <input type="checkbox"/> Respiratory depression <input type="checkbox"/> Hypertension Details:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, time to resolution (min): _____
	During treatment session? <input type="checkbox"/> Yes <input type="checkbox"/> No		
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	During treatment session? <input type="checkbox"/> Yes <input type="checkbox"/> No		
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	During treatment session? <input type="checkbox"/> Yes <input type="checkbox"/> No		
+Defined as any event that may jeopardize the patient or may require intervention to prevent one of the above outcomes.			
Report other product quality complaints or adverse events that are not defined above to: Janssen Pharmaceuticals, Inc. at 1-800-526-7736 or the FDA at 1-800-FDA-1088 or <a href="http://www.fda.gov/medwatch">www.fda.gov/medwatch</a> .			