Janssen CarePath

UPDATE 05.24

Patient Enrollment Form

Complete and fax this Form to 866-489-5955 or mail to PO Box 15510, Pittsburgh, PA 15244.
For assistance, call 877-CarePath (877-227-3728), Monday–Friday, 8:00 AM–8:00 PM, ET.

Simponi ARIA golimumab for infusion | Remicade INFLIXIMAB | Infliximab

A completed Patient Authorization Form, found on pages 3 and 4 of this document, is necessary to access certain patient support under Janssen CarePath. Please submit the Patient Authorization Form with this completed Patient Enrollment Form.

The information you provide will be used by a pharmacy affiliated with Janssen Biotech, Inc., and its service providers (Pharmacy) in connection with your patient's treatment. The information you provide will be used in accordance with The Notice of Privacy Practices ("Privacy Policy").

Comprehensive support to help your patients start and stay on prescribed treatment

We will verify insurance coverage, support and monitor the prior authorization process, provide reimbursement information, help find affordability options for eligible patients, and provide ongoing support to help patients stay on Janssen medications. This includes:

Janssen Patient Assistance Program: Patient assistance is available if your patient has commercial, employer-sponsored, or government coverage that does not fully meet their needs. Your patient may be eligible to receive their Janssen medication free of charge for up to one year if they meet the eligibility and income requirements for the Janssen Patient Assistance Program. To enroll your patient in the Janssen Patient Assistance Program, a SIMPONI ARIA®, REMICADE® or Infliximab Prescription via Janssen CarePath is required in section 5.

1. PATIENT INFORMATION (REQUIRED)

NAME (First, MI, Last) _____ SEX ☐ M ☐ F

DOB (MM/DD/YYYY) _____ ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____ EMAIL _____

CELL PHONE _____ HOME PHONE _____ WORK PHONE _____

PREFERRED NUMBER TO CALL ☐ Cell ☐ Home ☐ Work BEST TIME TO CONTACT ☐ Morning ☐ Afternoon ☐ Evening

☐ The patient has consented to treatment by the Pharmacy and has authorized the collection, use, and disclosure of their health information as described in the Privacy Policy. I understand that the Pharmacy may be contacting the patient by phone or otherwise concerning this program.

2. INSURANCE INFORMATION (REQUIRED. Complete fields below OR provide a copy of insurance cards.)

PRIMARY INSURANCE _____ CARDHOLDER _____

RELATIONSHIP TO CARDHOLDER _____ EMPLOYER _____ INS. CO. PHONE _____

POLICY # _____ GROUP # _____

SECONDARY INSURANCE _____ CARDHOLDER _____

RELATIONSHIP TO CARDHOLDER _____ EMPLOYER _____ INS. CO. PHONE _____

POLICY # _____ GROUP # _____

PRESCRIPTION DRUG INSURER _____ CARD/BIN # _____ PHONE _____

☐ Is patient a dependent of the insured (child <18 years; student >18 years)? Check if yes.

3. PRESCRIBER INFORMATION (REQUIRED)

PRESCRIBER NAME (First, Last) _____

SPECIALTY _____

PRACTICE NAME _____ OFFICE CONTACT _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

EMAIL _____ PHONE _____ FAX _____

MEDICAID/MEDICARE PROVIDER # _____ TAX ID # _____

STATE LICENSE # _____ UPIN/NPI # _____

Are you the prescribing specialist? (Required) ☐ YES ☐ NO: IF NO, REFERRING SPECIALIST _____

REFERRING PHYSICIAN SPECIALTY _____

4. PRIOR MEDICATIONS (REQUIRED. Specify—P=Prior, C=Current, F=Failure)

☐ Acetaminophen, ibuprofen, naproxen sodium, or other over-the-counter pain relievers _____			☐ Methotrexate _____
☐ 5-ASA _____	☐ Celebrex® _____	☐ Gold compounds _____	☐ Orencia® _____
☐ 6-MP _____	☐ Cimzia® _____	☐ Humira® _____	☐ Penicillamine _____
☐ Actemra® _____	☐ Corticosteroids _____	☐ Hydroxychloroquine _____	☐ Rituxan® _____
☐ Azathioprine _____	☐ Cyclophosphamide _____	☐ Indocin® _____	☐ Other _____
☐ Azulfidine® _____	☐ Cyclosporine _____	☐ Kineret® _____	
☐ Calcipotriene _____	☐ Enbrel® _____	☐ Leflunomide _____	

DATE OF DIAGNOSIS OR YEARS WITH DISEASE _____ PATIENT WEIGHT _____ lb _____ kg

PREVIOUS TB TEST (DATE) _____ HEPATITIS B VIRUS TEST (DATE) _____ SCHEDULED DATE OF INFUSION _____

5. PRESCRIPTION INFORMATION (REQUIRED. Complete if requesting a benefits investigation. Visit JanssenCarePath.com for ICD-10 codes or consult the ICD-10 code book for additional information)

☐ **SIMPONI ARIA® 50 mg/4 mL** DIAGNOSIS CODE _____ INDICATION _____

For adult patients with moderately to severely active rheumatoid arthritis, active psoriatic arthritis, and active ankylosing spondylitis

DOSING/FREQUENCY: 2 mg/kg at weeks 0 and 4, and every 8 weeks thereafter (The dosage regimen is based on the patient's body surface area [BSA]).

For pediatric patients 2 years of age and older with active polyarticular juvenile idiopathic arthritis (pJIA) and active psoriatic arthritis (PsA)

DOSING/FREQUENCY: 80 mg/m² at weeks 0 and 4, and every 8 weeks thereafter (The dosage regimen is based on the patient's body surface area [BSA]).

NUMBER OF PRIOR SIMPONI ARIA® INFUSIONS ☐ unknown ☐ 0 ☐ 1-3 ☐ 4+

☐ Induction: Infuse _____ mg IV at weeks 0, 4 Vials # (for 1 infusion) _____ Refills: 2

☐ Maintenance: Infuse _____ mg IV every 8 weeks thereafter Vials # (for 1 infusion) _____ Refills: _____

☐ **REMICADE® or ☐ Infliximab** DIAGNOSIS CODE _____ INDICATION _____

☐ Induction: Infuse _____ mg IV at weeks 0, 2, 6 Vials # (for 1 infusion) _____ Refills: 2

☐ Maintenance: Infuse _____ mg IV every _____ weeks thereafter Vials # (for 1 infusion) _____ Refills: _____

Janssen Prescription

Signature required to enroll eligible patients in Janssen Patient Assistance Program.

PRESCRIBER SIGNATURE (Dispense as written) _____ DATE _____

By submitting this prescription, I understand the Pharmacy will check the patient's eligibility for and may enroll the patient in certain support programs based on the results of the benefits investigation with patient consent. If the patient is eligible for support programs, I certify that I agree to the programs' requirements and will take the necessary actions described in the requirements for the patient. See program requirements on next page.

6. PREFERRED SITE OF INFUSION (REQUIRED. Fields below do not need to be completed if information is the same as in the Prescriber Information section)

☐ Prescribing MD's office ☐ Non-prescribing MD's office ☐ Hospital outpatient ☐ Home infusion/Infusion provider company ☐ Other

PHYSICIAN OR INFUSION PROVIDER NAME _____

PRACTICE/FACILITY NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

PHONE _____ FAX _____ CONTACT NAME _____

INSURANCE PROVIDER # _____ TAX ID # _____

Please see the full Prescribing Information, including Boxed Warning, and Medication Guides for SIMPONI ARIA®, REMICADE®, and Infliximab.

Information about your patient's insurance coverage, cost support options, and treatment support is given by service providers for Janssen CarePath. The information you get does not require you or your patient to use any Janssen product. Because the information we give you comes from outside sources, Janssen CarePath cannot promise the information will be complete. Janssen CarePath cost support is not for patients in the Johnson & Johnson Patient Assistance Foundation.

JANSSEN PATIENT ASSISTANCE PROGRAM

Your patient may be eligible to receive their Janssen medication(s) free of charge for up to one year if they have been prescribed a Janssen medication, have a financial hardship, and are currently enrolled in government, commercial, or employer group health insurance.

Your patient must meet the eligibility and income requirements to qualify for the patient assistance program.

Your patient is not eligible for free Janssen medication if their health insurance will cover the cost of their Janssen-prescribed medication if this application is denied. Some employers, insurers, and other companies force patients to apply for medically necessary medications from free product programs instead of covering such medications directly and immediately through insurance, which could lead to delays in care and discriminate against lower-income patients. These types of "Assistance Diversion Programs" are generally established by companies that profit by diverting resources away from patients in need. An Assistance Diversion Program is any insurer, employer, or third-party program that withholds coverage or payment for Patient's medically necessary drug until Patient has completed an application for free product assistance. Assistance Diversion Programs are prohibited by Janssen to make sure that help is available for patients with no safety net in place. Your patient's insurer must submit a Patient Eligibility Certification form to confirm that their drug coverage is not subject to an Assistance Diversion Program.

Your patient may not seek payment for the value of Janssen medications received from this program from any health plan, patient assistance foundation, flexible spending account, or healthcare savings account.

Before your patient enrolls in the patient assistance program, it is important they understand that they will be asked to provide personal information that may include their name, address, phone number, email address, financial information, and information related to their prescription medication insurance and treatment. This information will be used by Janssen Biotech, Inc., and its service providers to determine their eligibility for, enroll them in, and administer the program. The information will also be used to learn more about the people who use the program, to improve the program, and will be shared with service providers supporting the program.

If your patient has Medicare Prescription Drug Coverage (Part D) they may be asked to attest to or submit a report from their pharmacy or an Explanation of Benefits (EOB) statement from their insurer that shows their out-of-pocket costs for the current year. To qualify for the program, 4% of the patient's gross annual household income must be spent on out-of-pocket prescription expenses for the patient and/or other members of their household.

This program offer may not be used with any other coupon, discount, prescription savings card, free trial, or other offer. Offer good only in the United States and its territories. Void where prohibited, taxed, or limited by law. Program terms will expire at the end of each calendar year and may change or end without notice, including in specific states.

Your patient may end their participation in the program at any time by calling 877-CarePath (877-227-3728), Monday through Friday, 8:00 AM to 8:00 PM ET.

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janssen
PHARMACEUTICAL COMPANIES OF
Johnson & Johnson

Janssen Patient Support Program Patient Authorization Form

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

- **Download a copy, print, check the desired boxes, and sign. Your healthcare provider may scan the completed Form and upload on Provider Portal, or completed Form may be faxed to 866-489-5955 or mailed to Janssen CarePath, PO Box 15510, Pittsburgh, PA 15244**
- **You may be able to eSign a digital Form in your healthcare provider's office or on the Janssen CarePath Patient Account at MyJanssenCarePath.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.

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.

Janssen Patient Support Program Patient Authorization Form

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: Janssen CarePath, PO Box 15510, Pittsburgh, PA 15244.

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:

_____

