Tremfya with Me | Tremfya® (guselkumab)

Patient Enrollment Form

UPDATE 02.25

Complete and fax this form to 844-322-9402. All fields are required unless marked optional.

For assistance, prescribers can call 844-4withMe (844-494-8463), Monday–Friday, 8:00 AM–8:00 PM ET. A completed Patient Authorization Form, found on pages 3 and 4 of this document, is necessary to access certain patient support under TREMFYA withMe. Please have your patient sign the Patient Authorization Form and submit with this completed Patient Enrollment Form. The information you provide will be processed by Johnson & Johnson Health Care Systems Inc. and its service providers in accordance with its **Privacy Policy** and, if applicable, its affiliated, noncommercial dispensing pharmacy, Access Therapy Center ("Pharmacy"), in accordance with its **Notice of Privacy Practices**.

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

We will help 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 start and stay on TREMFYA®. Patient support available for eligible patients prescribed TREMFYA®:

TREMFYA withMe Guide Outreach: TREMFYA withMe offers a dedicated guide at no cost to eligible patients over 18 with a prescription for approved on-label use. After submitting this form, your patient can expect to receive a phone call from their TREMFYA withMe Guide within 1–2 business days. The Guide will describe the program to your patient and complete the enrollment process. A TREMFYA withMe Guide cannot reach out to your patient without an executed Patient Authorization Form, which can be found on pages 3 and 4 of this document.

Delay and Denial Support: TREMFYA withMe offers eligible patients subcutaneous TREMFYA® **at no cost** until their commercial insurance covers the medicine. To enroll your patient in Delay and Denial Support, a TREMFYA® prescription must be completed in section 5.

Johnson & Johnson Patient Assistance Program: If your patient is uninsured or if their insurance does not fully meet their needs, they may be eligible to receive their medicine from J&J at no cost for up to one year. Your patient must meet the eligibility and income requirements for the Johnson & Johnson Patient Assistance Program. See terms and conditions at **PatientAssistanceInfo.com/IMM**. To enroll your patient in the Johnson & Johnson Patient Assistance Program, a TREMFYA® prescription is required in section 5.

1. PATIENT INFORMATION

FIRST NAME _____ LAST NAME _____ SEX _____ DOB (MM/DD/YYYY) _____

PHONE _____ EMAIL ADDRESS _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

☐ 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

Provide a copy of the front and back of insurance cards. (If providing copy of insurance card, skip to section 3. Prescriber Information.)

☐ The patient has no insurance and has checked eligibility requirements or applied to all available options for free or minimal cost insurance or other assistance. If the patient was previously enrolled in a patient assistance program, please provide the patient ID #: _____

PHARMACY INSURANCE (Rx) _____ INSURANCE PROVIDER PHONE _____

Rx GROUP # _____ Rx ID # _____ Rx BIN # _____ Rx PCN # _____

Rx CARDHOLDER FIRST NAME _____ Rx CARDHOLDER LAST NAME _____ Rx RELATIONSHIP TO PATIENT _____

Failure to provide this information may result in delay of the benefits investigation.

MEDICAL INSURANCE (MI) _____ MI GROUP # _____ MI ID # _____

MI CARDHOLDER FIRST NAME _____ MI CARDHOLDER LAST NAME _____ MI RELATIONSHIP TO PATIENT _____

3. PRESCRIBER INFORMATION

PRESCRIBER FIRST NAME _____ PRESCRIBER LAST NAME _____ NPI # _____ TAX ID # _____

OFFICE NAME _____ OFFICE CONTACT FIRST NAME _____ OFFICE CONTACT LAST NAME _____

PTAN # _____ OFFICE PHONE _____ OFFICE FAX _____

OFFICE ADDRESS _____ OFFICE CITY _____ OFFICE STATE _____ OFFICE ZIP CODE _____

PROVIDER EMAIL ADDRESS _____

4. CLINICAL INFORMATION (Information requested is for benefits investigation purposes only.)

PRIMARY DIAGNOSIS (select one):

PSORIASIS ☐ L40.0 ☐ Other ICD-10 Code: _____

ACTIVE PSORIATIC ARTHRITIS ☐ L40.50 ☐ Other ICD-10 Code: _____

DATE OF DIAGNOSIS OR YEARS WITH DISEASE: _____

SECONDARY DIAGNOSIS (if any): _____

ICD-10 Code: _____

PRIOR THERAPIES:

☐ Arava® ☐ Corticosteroids ☐ Cosentyx® ☐ Cyclosporine

☐ Enbrel® ☐ Humira® ☐ Methotrexate ☐ Otezla®

☐ Phototherapy ☐ Skyrizi® ☐ Soriatane® ☐ Stelara®

☐ Taltz® ☐ Xeljanz® ☐ None ☐ Other _____

5. PRESCRIPTION INFORMATION (Required to complete benefits investigation.)

Rx DIRECTIONS

STARTER DOSE:

☐ Single-dose One-Press patient-controlled injector; 100 mg/mL SC at ☐ Week 0 ☐ Week 4 (NDC: 57894-640-11)

☐ Single-dose prefilled syringe; 100 mg/mL SC at ☐ Week 0 ☐ Week 4 (NDC: 57894-640-01)

MAINTENANCE THERAPY:

☐ Single-dose One-Press patient-controlled injector; 100 mg/mL SC every 8 weeks Refills #_____

☐ Single-dose prefilled syringe; 100 mg/mL SC every 8 weeks Refills # _____

TREMFYA® Prescription

PRESCRIBER SIGNATURE(S) (NO STAMPS ALLOWED) REQUIRED TO VALIDATE PRESCRIPTION: I certify that therapy with TREMFYA® is medically necessary for this patient. I will be supervising the patient's treatment accordingly, and I have reviewed the current TREMFYA® Prescribing Information. By signing below, I authorize the Pharmacy, its affiliates, agents, and contractors to, as applicable, (i) dispense this prescription to patient with patient's consent if eligible for the TREMFYA withMe Access Program and/or Johnson & Johnson Patient Assistance Program; and (ii) act on my behalf for the limited purposes of transmitting this prescription, by any means allowed under applicable law to the appropriate specialty pharmacy for my patient.

Signature required to enroll eligible patients in Delay and Denial Support or Johnson & Johnson Patient Assistance Program.

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.

PRESCRIBER SIGNATURE (Dispense as written) _____ DATE _____

Commercial Pharmacy Prescription (OPTIONAL)

Patient or provider preferred pharmacy _____

PRESCRIBER SIGNATURE (Dispense as written) _____ DATE _____

Please see the full Prescribing Information and Medication Guide for TREMFYA®.

The patient support and resources provided by TREMFYA withMe are not intended to give medical advice, replace a treatment plan from the patient's healthcare provider, offer services that would normally be performed by the provider's office, or serve as a reason to prescribe TREMFYA® (guselkumab).

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

DELAY AND DENIAL SUPPORT

TREMFYA withMe offers eligible patients subcutaneous TREMFYA® **at no cost** until their commercial insurance covers the medicine. See program requirements below.

To be eligible, patient must have:

1. a TREMFYA® prescription for an FDA-approved use
2. commercial insurance with biologics coverage
3. a delay of more than 5 business days or a denial of treatment from their insurance

In addition, for patient to be eligible, the Prescriber must submit a program enrollment form and a coverage determination form to their insurance.

If patient's medicine is denied, the Prescriber must also submit a letter or appeal to their insurance within 90 days of when they become eligible for patient to stay in the program.

Patient is not eligible if:

1. patient uses any state or federal government-funded healthcare program to cover medicine costs. Examples of these programs are Medicare, Medicaid, TRICARE, Department of Defense, and Veterans Administration
2. patient coverage is denied due to non-FDA-approved use, missing information on coverage determination form, or invalid clinical rationale

Delay and Denial Support requires a periodic check of the patient's insurance coverage status to confirm their continued eligibility. The patient remains eligible until their commercial insurance covers their medicine.

Delay and Denial Support covers the cost of medicine only—not associated administration cost. Prescriber cannot bill commercial insurance plan for any part of the prescribed subcutaneous treatment. Patient cannot submit the value of the free product as a claim for payment to any health plan. Program good only in the United States and its territories. Void where prohibited, taxed, or limited by law. Program terms may change.

JOHNSON & JOHNSON PATIENT ASSISTANCE PROGRAM

Patient assistance is available if your patient is uninsured, or has commercial, employer-sponsored, or government coverage that does not fully meet their needs. Your patient may be eligible to receive their medicine from J&J **at no cost** for up to one year if they meet the following requirements:

- Your patient is uninsured or has a commercial or employer-sponsored insurance plan or government coverage, such as Medicare, Medicaid, TRICARE, U.S. Department of Veterans Affairs health care, or U.S. Department of Defense health care
- Your patient lives in the United States or a U.S. territory
- Your patient is treated as an outpatient by a healthcare provider licensed in the U.S.
- Your patient has been prescribed an eligible medicine from J&J
- Your patient meets the income eligibility requirements
- **For Medicare Part D Patients Only:**
  - Your patient demonstrates they are not eligible for the Low-Income Subsidy (LIS)
  - Your patient spends more than 4% of their gross annual household income on prescription drugs

To learn more about income requirements, terms & conditions, and how to enroll your patient in the Johnson & Johnson Patient Assistance Program, please visit **PatientAssistanceInfo.com/IMM** or call 877-227-3728.

Please see the full Prescribing Information and Medication Guide for TREMFYA®.

Johnson & Johnson

Patient support program patient authorization form

Why should I sign this Form?

This Form gives your Healthcare Providers permission to use and share your medical information with the patient support programs offered by Johnson & Johnson.

Section 1 What health information am I sharing and with whom?

I give permission for my Healthcare Providers and Insurers (eg, my health insurance plans) to share my Protected Health Information, as described on this Form.

My Protected Health Information includes information related to: my medical condition, treatment, prescriptions, and health insurance coverage

My Healthcare Providers may include: physicians, pharmacists, specialty pharmacies, other healthcare providers, and staff members at my healthcare providers' offices

I give permission to these people or groups to receive and use my Protected Health Information (collectively "J&J"):

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

My Protected Health Information may be shared by J&J with these people and groups: my Insurers, my Healthcare Providers, any other people given permission to receive and use my Protected Health Information (as mentioned above), anyone I give permission to as an additional contact, and service providers who review data from J&J's patient support programs

J&J and the other groups on this Form may share information about me in 2 ways: as permitted on this Form, and if any information that identifies me is removed from what has been shared

Section 2 How can giving permission help with patient support programs and access?

I give permission to J&J to receive, use, and share my Protected Health Information to:

- See if I qualify for, sign me up for, contact me about, and provide services relating to J&J's patient support programs. This includes in-home services
- Manage J&J's patient support programs
- Give me resources and information related to my J&J medicine in connection with J&J's patient support programs. This includes educational and adherence materials
- Communicate with my Healthcare Providers about access, reimbursement, and fulfillment for my J&J medicine
- Inform my Healthcare Provider that I am enrolled in J&J's patient support programs
- Help verify and coordinate coverage for J&J medicines with my Insurers and Healthcare Providers
- Help with prescription or treatment location and associated scheduling
- Conduct analysis to help J&J evaluate, create, and improve their patient support services and products for patients prescribed J&J medicines
- Share information from J&J's patient support programs that may be useful for my care

Section 3 What should I understand before signing this Form?

I understand that:

- J&J 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 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 in or receive assistance from J&J's patient support programs
- The following groups may be paid by J&J for their services and data, including Protected Health Information:
  - Pharmacies that dispense and ship my medicine
  - Service providers for J&J's patient support programs
- This Form will remain in effect 10 years from the date I signed below, except if:
  - State law requires a shorter time or
  - I am no longer in any patient support program from J&J
- Information collected before that date may continue to be used for the purposes noted in this Form
  - I may cancel the permissions given by this Form at any time by letting J&J know in writing at: TREMFYA withMe, 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 J&J
  - If I cancel my permission, it will not affect how J&J uses and shares my Protected Health Information received by J&J before my cancellation
  - I may request a copy of this Form

For privacy rights and choices specific to California, Colorado, Connecticut, Utah, Virginia, and Washington residents, please see J&J's US Supplemental Privacy Notice available at ***InnovativeMedicine.JNJ.com/us/privacy-policy#supplemental***

Section 4 Fill in Personal Information & Sign Patient Authorization Form

Patient name (print): _____ **Email Address:** _____

Patient sign here: _____ **Date:** _____

If 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:

_____

Optional Resources

Permission for communications outside of J&J's patient support programs:

☐ Yes, I would like to receive communications about my J&J medicine

☐ Yes, I would like to receive communications about other products and services from J&J

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 J&J's patient support programs or to receive any other communications I have selected. Cell phone number: _____

Sign and return this Form to:

Fax to: 844-322-9402

TREMFYA withMe
PO Box 15510, Pittsburgh, PA 15244

Or, eSign a digital Form:

In your healthcare provider's office

At **Account.JNJwithMe.com**

