Stelara withMe | Stelara® (ustekinumab)

Rheumatology and Dermatology Patient Enrollment Form

UPDATE 01.26

Complete and fax this form to 866-769-3903. All fields are required unless marked optional. Please see Consents and Certifications on page 5 for full details.
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 page 4 of this document, is necessary to access certain patient support under STELARA withMe (the "Program" or "J&J withMe"). Please have your patient or the patient's legally authorized representative sign the Patient Authorization Form and submit with this completed Patient Enrollment Form.

▼ TO BE COMPLETED BY PATIENT AND PROVIDER ▼

1. Patient Contact Information

FIRST NAME _____ LAST NAME _____ DATE OF BIRTH _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____ SEX ☐ MALE ☐ FEMALE

PHONE (one required): HOME _____ MOBILE _____ EMAIL (optional) _____

2. Patient Consents

CONSENT TO PROCESS MY SENSITIVE PERSONAL INFORMATION: Through my submission of this STELARA withMe Patient Enrollment Form, I consent to the collection, use, and disclosure of my sensitive personal information, including health data, for the purposes described in this form and as described in Johnson & Johnson's **Privacy Statement**. My consent is required to process sensitive personal information under certain privacy laws, and I have the right to withdraw my consent at any time by visiting "Privacy Request Form," accessible via the Privacy Statement.

☐ **TEXT MESSAGE CONSENT (OPTIONAL):** I consent to receive automated and recurring text messages about the Program from Johnson & Johnson as set forth on page 4 to the mobile number provided above. Message and data rates may apply. Message frequency varies. I understand that I am not required to consent as a condition of participating in STELARA withMe, purchasing any goods or services, or receiving any other communications I have selected. I can reply HELP for help. I can reply STOP to opt out at any time.

☐ **MARKETING CONSENT (OPTIONAL):** I consent to receive communications via mail, email, and telephone from Johnson & Johnson regarding its products, programs, services, scientific research and other research opportunities, and for online targeted advertising, as further described in Johnson & Johnson's **Privacy Statement**.

Please see Patient Consents and Certifications on page 5 for full details.

3. Insurance Information

Provide a copy of the front and back of insurance card(s). (If providing copy of insurance card(s), skip to section 4. Clinical 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 #:** _____

Medical Insurance _____ POLICY # _____ GROUP # _____

Pharmacy Insurance _____ PCN # _____ GrpRX # _____

POLICY # _____ CARD/BIN # _____

▼ TO BE COMPLETED BY PROVIDER ▼

4. Clinical Information

PRIMARY DIAGNOSIS: SELECT ONE:

☐ L40.0 (Psoriasis vulgaris)
☐ L40.50 (Arthropathic psoriasis, unspecified)
☐ L40.51 (Distal interphalangeal psoriatic arthropathy)
☐ L40.52 (Psoriatic arthritis mutilans)
☐ L40.53 (Psoriatic spondylitis)
☐ L40.54 (Psoriatic juvenile arthropathy)
☐ L40.59 (Other psoriatic arthropathy)
☐ Other ICD-10 Code _____

SECONDARY DIAGNOSIS: ICD-10 CODE _____

TREATMENT START DATE (MM/DD/YYYY): _____ ☐ Not yet started. If not yet started, estimated start date (MM/DD/YYYY): _____

PATIENT WEIGHT _____ kg % BSA AFFECTED _____

PRIOR MEDICINES (optional) _____

5. Prescriber Information

PRESCRIBER NAME (First, Last) _____

OFFICE CONTACT (optional) _____ PTAN (Medicare patients only) _____

PRACTICE NAME _____ NPI # _____ TAX ID # (optional) _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

EMAIL _____ PHONE _____ FAX _____

6. Benefits Investigation (Required to complete benefits investigation. Do not prescribe these products together.)

I would like to request a benefits investigation for STELARA® (ustekinumab).

☐ 1 single-dose 45 mg prefilled syringe ☐ 1 single-dose 90 mg prefilled syringe ☐ 1 single-dose 45 mg vial ☐ 2 single-dose 45 mg vials

I would also like to request a benefits investigation for TREMFYA® (guselkumab). (Pharmacy Insurance information must be provided.)

☐ 1 single-dose 100 mg One-Press patient-controlled injector ☐ 1 single-dose 100 mg prefilled syringe ☐ 1 single-dose 100 mg prefilled pen (TREMFYA® PEN)

SITE OF CARE: (Required if different from prescriber)

☐ Prescriber's Office ☐ Non-Prescriber's Office ☐ Hospital Outpatient ☐ Other

PHYSICIAN NAME _____ OFFICE CONTACT NAME _____

SITE NAME _____ NPI # _____ TAX ID # _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

PHONE _____ FAX _____

7. Prescription Information (Required to complete benefits investigation.)

STELARA® Rx DIRECTIONS (Select all that apply.)

VIAL STARTER DOSE for plaque psoriasis and active psoriatic arthritis (ages 6–17) weighing less than 60 kg

☐ 1 single-dose 45 mg vial at ☐ Week 0 ☐ Week 4

VIAL MAINTENANCE THERAPY for plaque psoriasis and active psoriatic arthritis (ages 6–17) weighing less than 60 kg

☐ 1 single-dose 45 mg vial every 12 weeks Refills #_____

PREFILLED SYRINGE STARTER DOSE

☐ 1 single-dose 45 mg SC prefilled syringe ☐ Week 0 ☐ Week 4
☐ 1 single-dose 90 mg SC prefilled syringe ☐ Week 0 ☐ Week 4

PREFILLED SYRINGE MAINTENANCE THERAPY

☐ 1 single-dose 45 mg SC prefilled syringe every 12 weeks Refills #_____
☐ 1 single-dose 90 mg SC prefilled syringe every 12 weeks Refills #_____

PRESCRIBER SIGNATURE(S) (NO STAMPS ALLOWED) REQUIRED TO VALIDATE PRESCRIPTION: I certify that therapy with STELARA® is medically necessary for this patient. I will be supervising the patient's treatment accordingly, and I have reviewed the current STELARA® Prescribing Information. By signing below, I authorize the Pharmacy, its affiliates, agents, and contractors to act on my behalf for the limited purposes of transmitting this prescription, by any means allowed under applicable law, to the appropriate pharmacy.

STELARA® Support Program Prescription

By submitting this prescription, I understand the Program 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 descriptions, program links, and Prescriber Certifications on page 5.

PRESCRIBER SIGNATURE (Dispense as written) _____ DATE _____

Commercial Pharmacy Prescription (optional): If signed, the prescription will triage to the insurance-mandated specialty pharmacy. Do NOT sign if triage is not requested.

Patient- or Provider-Preferred Pharmacy Information (Please complete if insurance-mandated pharmacy is not required) _____

PRESCRIBER SIGNATURE (Dispense as written) _____ DATE _____

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

Clear Form Print Form

INDICATIONS

STELARA® (ustekinumab) is indicated for the treatment of adults and pediatric patients 6 years and older with active psoriatic arthritis.

STELARA® (ustekinumab) is indicated for the treatment of adults and pediatric patients 6 years and older with moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy.

STELARA® (ustekinumab) is indicated for the treatment of adult patients with moderately to severely active Crohn's disease.

STELARA® (ustekinumab) is indicated for the treatment of adult patients with moderately to severely active ulcerative colitis.

IMPORTANT SAFETY INFORMATION

STELARA® (ustekinumab) is contraindicated in patients with clinically significant hypersensitivity to ustekinumab or to any of the excipients.

Infections

STELARA® may increase the risk of infections and reactivation of latent infections. Serious bacterial, mycobacterial, fungal, and viral infections requiring hospitalization or otherwise clinically significant infections were reported. In patients with plaque psoriasis, these included diverticulitis, cellulitis, pneumonia, appendicitis, cholecystitis, sepsis, osteomyelitis, viral infections, gastroenteritis, and urinary tract infections. In patients with psoriatic arthritis, this included cholecystitis. In patients with Crohn's disease, these included anal abscess, gastroenteritis, ophthalmic herpes zoster, pneumonia, and *Listeria* meningitis. In patients with ulcerative colitis, these included gastroenteritis, ophthalmic herpes zoster, pneumonia, and listeriosis.

Treatment with STELARA® should not be initiated in patients with a clinically important active infection until the infection resolves or is adequately treated. Consider the risks and benefits of treatment prior to initiating use of STELARA® in patients with a chronic infection or a history of recurrent infection. Instruct patients to seek medical advice if signs or symptoms suggestive of an infection occur while on treatment with STELARA® and discontinue STELARA® for serious or clinically significant infections until the infection resolves or is adequately treated.

Theoretical Risk for Vulnerability to Particular Infections

Individuals genetically deficient in IL-12/IL-23 are particularly vulnerable to disseminated infections from mycobacteria, *Salmonella*, and *Bacillus Calmette-Guerin* (BCG) vaccinations. Serious infections and fatal outcomes have been reported in such patients. It is not known whether patients with pharmacologic blockade of IL-12/IL-23 from treatment with STELARA® may be susceptible to these types of infections. Consider diagnostic testing, eg, tissue culture, stool culture, as dictated by clinical circumstances.

Pre-Treatment Evaluation of Tuberculosis (TB)

Evaluate patients for TB prior to initiating treatment with STELARA®. Do not administer STELARA® to patients with active tuberculosis infection. Initiate treatment of latent TB before administering STELARA®. Closely monitor patients receiving STELARA® for signs and symptoms of active TB during and after treatment.

Malignancies

STELARA® is an immunosuppressant and may increase the risk of malignancy. Malignancies were reported among patients who received STELARA® in clinical trials. The safety of STELARA® has not been evaluated in patients who have a history of malignancy or who have a known malignancy. There have been reports of the rapid appearance of multiple cutaneous squamous cell carcinomas in patients receiving STELARA® who had risk factors for developing non-melanoma skin cancer (NMSC). All patients receiving STELARA®, especially those >60 years or those with a history of PUVA or prolonged immunosuppressant treatment, should be monitored for the appearance of NMSC.

Serious Hypersensitivity Reactions

Serious hypersensitivity reactions, including anaphylaxis and angioedema, have been reported with STELARA® in clinical trials and postmarketing. Some serious hypersensitivity reactions have occurred during the first intravenous dose of STELARA®. If a severe or clinically significant hypersensitivity reaction occurs, discontinue STELARA® immediately and initiate appropriate medical treatment.

Posterior Reversible Encephalopathy Syndrome (PRES)

Two cases of posterior reversible encephalopathy syndrome (PRES), also known as Reversible Posterior Leukoencephalopathy Syndrome (RPLS), were reported in clinical trials. Cases have also been reported in postmarketing experience in patients with psoriasis, psoriatic arthritis and Crohn's disease. Clinical presentation included headaches, seizures, confusion, visual disturbances, and imaging changes consistent with PRES a few days to several months after ustekinumab initiation. A few cases reported latency of a year or longer. Patients recovered with supportive care following withdrawal of ustekinumab.

Monitor all patients treated with STELARA® for signs and symptoms of PRES. If PRES is suspected, promptly administer appropriate treatment and discontinue STELARA®.

Immunizations

Prior to initiating therapy with STELARA®, patients should receive all age-appropriate immunizations as recommended by current immunization guidelines. Patients being treated with STELARA® should avoid receiving live vaccines. Avoid administering BCG vaccines during treatment with STELARA® or for one year prior to initiating treatment or one year following discontinuation of treatment. Caution is advised when administering live vaccines to household contacts of patients receiving STELARA® because of the potential risk for shedding from the household contact and transmission to patient. Non-live vaccinations received during a course of STELARA® may not elicit an immune response sufficient to prevent disease.

Noninfectious Pneumonia

Cases of interstitial pneumonia, eosinophilic pneumonia, and cryptogenic organizing pneumonia have been reported during post-approval use of STELARA®. Clinical presentations included cough, dyspnea, and interstitial infiltrates following one to three doses. Serious outcomes have included respiratory failure and prolonged hospitalization. Patients improved with discontinuation of therapy and, in certain cases, administration of corticosteroids. If diagnosis is confirmed, discontinue STELARA® and institute appropriate treatment.

Allergen Immunotherapy

STELARA® may decrease the protective effect of allergen immunotherapy (decrease tolerance) which may increase the risk of an allergic reaction to a dose of allergen immunotherapy. Therefore, caution should be exercised in patients receiving or who have received allergen immunotherapy, particularly for anaphylaxis.

Most Common Adverse Reactions

The most common adverse reactions (≥3% and higher than that with placebo) in adults from plaque psoriasis clinical trials for STELARA® 45 mg, STELARA® 90 mg, or placebo were: nasopharyngitis (8%, 7%, 8%), upper respiratory tract infection (5%, 4%, 5%), headache (5%, 5%, 3%), and fatigue (3%, 3%, 2%), respectively. The safety profile in pediatric patients with plaque psoriasis was similar to that of adults with plaque psoriasis. In psoriatic arthritis (PsA) trials, a higher incidence of arthralgia and nausea was observed in patients treated with STELARA® when compared with placebo (3% vs 1% for both). In Crohn's disease induction trials, common adverse reactions (3% or more of patients treated with STELARA® and higher than placebo) reported through Week 8 for STELARA® 6 mg/kg intravenous single infusion or placebo included: vomiting (4% vs 3%). In the Crohn's disease maintenance trial, common adverse reactions (3% or more of patients treated with STELARA® and higher than placebo) reported through Week 44 for STELARA® 90 mg subcutaneous injection or placebo were: nasopharyngitis (11% vs 8%), injection site erythema (5% vs 0%), vulvovaginal candidiasis/mycotic infection (5% vs 1%), bronchitis (5% vs 3%), pruritus (4% vs 2%), urinary tract infection (4% vs 2%) and sinusitis (3% vs 2%). In the ulcerative colitis induction trial, common adverse reactions (3% or more of patients treated with STELARA® and higher than placebo) reported through Week 8 for STELARA® 6 mg/kg intravenous single infusion or placebo included: nasopharyngitis (7% vs 4%). In the ulcerative colitis maintenance trial, common adverse reactions (3% or more of patients treated with STELARA® and higher than placebo) reported through Week 44 for STELARA® 90 mg subcutaneous injection or placebo included: nasopharyngitis (24% vs 20%), headache (10% vs 4%), abdominal pain (7% vs 3%), influenza (6% vs 5%), fever (5% vs 4%), diarrhea (4% vs 1%), sinusitis (4% vs 1%), fatigue (4% vs 2%), and nausea (3% vs 2%).

cp-124933v8

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

INDICATIONS

TREMFYA® (guselkumab) is indicated for the treatment of adults and pediatric patients 6 years of age and older who also weigh at least 40 kg with moderate to severe plaque psoriasis and who are candidates for systemic therapy or phototherapy.

TREMFYA® is indicated for the treatment of adults and pediatric patients 6 years of age and older who also weigh at least 40 kg with active psoriatic arthritis.

TREMFYA® is indicated for the treatment of adult patients with moderately to severely active ulcerative colitis.

TREMFYA® is indicated for the treatment of adult patients with moderately to severely active Crohn's disease.

IMPORTANT SAFETY INFORMATION

CONTRAINDICATIONS

TREMFYA® is contraindicated in patients with a history of serious hypersensitivity reaction to guselkumab or to any of the excipients.

WARNINGS AND PRECAUTIONS

Hypersensitivity Reactions

Serious hypersensitivity reactions, including anaphylaxis, have been reported with postmarket use of TREMFYA®. Some cases required hospitalization. If a serious hypersensitivity reaction occurs, discontinue TREMFYA® and initiate appropriate therapy.

Infections

TREMFYA® may increase the risk of infection. Treatment with TREMFYA® should not be initiated in patients with any clinically important active infection until the infection resolves or is adequately treated.

Consider the risks and benefits of treatment prior to prescribing TREMFYA® in patients with a chronic infection or a history of recurrent infection. Instruct patients receiving TREMFYA® to seek medical help if signs or symptoms of clinically important chronic or acute infection occur. If a patient develops a clinically important or serious infection, or is not responding to standard therapy, closely monitor and discontinue TREMFYA® until the infection resolves.

Tuberculosis (TB)

Evaluate patients for TB infection prior to initiating TREMFYA® treatment. Do not administer TREMFYA® to patients with active TB infection. Initiate treatment of latent TB prior to administering TREMFYA®. Consider anti-TB therapy prior to initiating TREMFYA® in patients with a past history of latent or active TB in whom an adequate course of treatment cannot be confirmed. Monitor all patients for signs and symptoms of active TB during and after TREMFYA® treatment.

Hepatotoxicity

A serious adverse reaction of drug-induced liver injury was reported in a clinical trial subject with Crohn's disease following three doses of a higher than recommended induction regimen.

In patients with Crohn's disease or ulcerative colitis, evaluate liver enzymes and bilirubin at baseline, for at least 16 weeks of treatment, and periodically thereafter according to routine patient management. In patients with plaque psoriasis or psoriatic arthritis, if clinically indicated, evaluate liver enzymes and bilirubin at baseline, and periodically thereafter according to routine patient management.

Consider other treatment options in patients with evidence of acute liver disease or cirrhosis. Prompt investigation of the cause of liver enzyme elevation is recommended to identify potential cases of drug-induced liver injury. Interrupt treatment if drug-induced liver injury is suspected, until this diagnosis is excluded. Instruct patients to seek immediate medical attention if they experience symptoms suggestive of hepatic dysfunction.

Immunizations

Prior to initiating TREMFYA®, consider completion of all age-appropriate immunizations according to current immunization guidelines. Avoid use of live vaccines in patients treated with TREMFYA®.

ADVERSE REACTIONS

Most common adverse reactions associated with TREMFYA® include: plaque psoriasis and psoriatic arthritis adverse reactions (≥1%): upper respiratory infections, headache, injection site reactions, arthralgia, bronchitis, diarrhea, gastroenteritis, tinea infections, and herpes simplex infections. Ulcerative colitis adverse reactions (≥3%): injection site reactions, arthralgia, upper respiratory tract infections, headache, gastroenteritis, fatigue, pyrexia, and rash. Crohn's disease adverse reactions (≥3%): respiratory tract infections, abdominal pain, injection site reactions, headache, fatigue, arthralgia, diarrhea, and gastroenteritis.

The safety profile observed in pediatric patients 6 years of age and older treated with TREMFYA® up to 52 weeks was consistent with the safety profile observed in adult patients with moderate to severe plaque psoriasis.

The overall safety profile observed in adult patients with psoriatic arthritis is generally consistent with the safety profile in adult patients with plaque psoriasis, with the addition of bronchitis and neutrophil count decreased.

cp-82625v9

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

Dosage Forms and Strengths: TREMFYA® is available as 100 mg/mL and 200 mg/2 mL for subcutaneous injection and as a 200 mg/20 mL (10 mg/mL) single-dose vial for intravenous infusion.

PATIENT AUTHORIZATION FORM ("AUTHORIZATION")

By signing below, 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 ("PHI") as described under J&J's support programs. My PHI includes any and all information related to my medical condition, treatment, prescriptions, health insurance coverage, and other information contained in the Patient Enrollment Form.

I agree that the following entities are permitted to receive, use, and share my PHI:

- Johnson & Johnson Health Care Systems Inc., its affiliated companies, including Patient Service Center LLC, agents, and representatives (collectively "J&J"); and
- Providers of other sources of funding (including foundations and co-pay assistance providers), service providers for J&J's support programs (including subcontractors or healthcare providers helping J&J run the program), and service providers maintaining, transmitting, de-identifying, aggregating, or analyzing data from J&J's support programs (collectively, "Service Providers");
- Pharmacies involved in my care; and Insurers

Also, I give permission to J&J, the Service Providers, my Healthcare Providers, and my Insurers to receive, use, and share my PHI in order to:

- see if I qualify for, sign me up for, contact me about, and provide services relating to J&J's patient support programs, including in-home services
- communicate with my Healthcare Providers regarding access to, reimbursement for, and fulfillment of my J&J medicine, and to tell my Healthcare Provider that I am participating in a support program from J&J
- verify, assist with, and coordinate my coverage for my J&J medicine with my Insurers and Healthcare Providers
- coordinate prescription or treatment location and associated scheduling
- conduct analysis to help J&J evaluate, create, and improve its products, services, and customer support for patients prescribed J&J medicines
- share and give access to information created by J&J's patient support programs that may be useful for my care
- communicate with me by telephone, text message, or email regarding J&J's support programs or other J&J medicines, products, or services for the purposes set forth in the Patient Enrollment Form

I understand that J&J and the Service Providers will use reasonable efforts to keep my information private but once my PHI is disclosed as allowed on this Authorization, it may no longer be protected by federal privacy laws. I understand that I am not required to sign this Authorization. My choice about whether to sign will not change how my Healthcare Providers or Insurers treat me. If I do not sign this Authorization, or cancel or remove my permission later, I understand I will not be able to participate in or receive assistance from certain J&J support programs. I understand that pharmacies that dispense and ship my medicine and service providers for J&J's support programs may be paid by J&J for their services and data. This may include payment for sharing PHI and other data in connection with this program, as allowed on this Authorization.

I understand I may request a copy of this Authorization. This Authorization 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 J&J's support programs. Information collected before that date may continue to be used for the purposes set forth in this Authorization. I understand that I may cancel the permissions given by this Authorization at any time by letting J&J know in writing at: Johnson & Johnson, 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. I further understand that if I cancel my permission it will not affect how J&J uses and shares my PHI received by J&J prior to my cancellation.

My signature below certifies that I have read, understood, and agreed to the release of my protected health information pursuant to this Authorization.

REQUIRED – SIGNATURE OF PATIENT OR PATIENT'S LEGALLY AUTHORIZED REPRESENTATIVE*:

_____ Date: _____

Print Patient Name: _____ Email Address: _____

Print Legally Authorized Representative Name (if applicable): _____

Relationship to Patient (if applicable): _____

*Only individuals with legal authority to make medical decisions for the patient may sign.

Johnson&Johnson

Please provide this Consents and Certifications page to your patient or the caregiver of your pediatric patient

Patient Consents and Certifications

Enrolling in STELARA withMe. I am enrolling in STELARA withMe, and I authorize Johnson & Johnson Health Care Systems Inc., its affiliated companies, including Patient Service Center LLC, and its vendors, agents, and representatives (collectively, "Johnson & Johnson") to provide me support under the Program. Such support may include:

(i) **Access and Affordability Support:** The Program will help you understand your insurance coverage, cost support options, and support offerings like the STELARA withMe Savings Program. To learn more, visit **STELARAwithMeSavings.com**.

Verification of Eligibility. If applicable, I authorize Johnson & Johnson to verify my eligibility for the Program, and I understand that such verification may include contacting me or my healthcare provider for additional information and/or reviewing additional insurance, medical information, and/or financial information. I understand that eligibility for participation in support offerings will be verified periodically.

Conditions of Participation. If I participate in the STELARA withMe Savings Program, I certify that I will not submit any costs paid by the Program as a claim for payment to any health plan, foundation, flexible spending account, or healthcare savings account. I agree to notify the Program if my insurance changes. Additionally, I understand that the Program may be changed or discontinued without notice.

Use of Personal Information. I understand that my personal health data or the patient's (if pediatric patient), contact information, and other identifying information shared by me, my/the patient's healthcare provider, or others with Johnson & Johnson is collected to administer the Program, as explained in Johnson & Johnson's **Privacy Statement**.

I understand my consent is needed for processing sensitive personal data under certain privacy laws, and I can withdraw my consent anytime by completing the Privacy Request Form found in the Privacy Statement.

Depending on where I live, I may have rights regarding my information privacy, including requesting access to or deletion of my/the patient's personal information. California residents have specific privacy rights detailed in Johnson & Johnson's California privacy notice.

I understand Johnson & Johnson might not be required to fulfill my requests in certain situations. To exercise these rights, I can contact Johnson & Johnson at 1-800-526-7736 or complete the Privacy Request Form in the Privacy Statement.

Communications. I authorize Johnson & Johnson to communicate with me by mail, email, telephone (including cell phone) and, if I indicate my agreement and consent in Section 2 on page 1, by text message (automated and recurring) at the address, email address, phone number, and mobile telephone number(s) provided in Section 1 on page 1. I agree to notify Johnson & Johnson promptly if any of my contact information changes in the future. I understand and acknowledge that communications via mail, email, and telephone may include information about the Program, and, if I indicate my agreement and consent in Section 2 on page 1, information about STELARA®, disease state and products, promotions, services, research studies, educational and adherence materials, and to seek my opinion about such information and topics, including market research and disease-related surveys. I understand and acknowledge that communications via text message may include information about the Program. I understand that I may opt out of receiving future communications at any time by notifying Johnson & Johnson or by following the instructions provided. I understand that if I opt in to receive text messages, the frequency of these messages may vary. I understand that I may opt out of receiving future text messages at any time by replying "STOP," and that I can get help for text messages at any time by replying "HELP" for assistance. Message and data rates may apply. For terms and conditions, please **click here**. I understand and acknowledge that my personal information, including my/the patient's health information, may be used or disclosed as part of the communications, including in any voicemails. Communications transmitted via unencrypted email or text message over an open network may be inherently unsecured, and there is no assurance of confidentiality for information communicated in this manner. Further, emails and text messages have inherent privacy risks, especially when access to computers or mobile devices is not password protected. Nevertheless, I want Johnson & Johnson to communicate with me via email and/or text message as detailed herein. Lastly, I understand that my consent to receive the communications is not required as a condition of participating in the Program, purchasing any goods or services, or receiving any other selected communications from Johnson & Johnson.

Prescriber Certifications

By submitting the Patient Enrollment Form, I certify that: The person named on the form is my patient; the information provided therein is, to the best of my knowledge, current, complete, and accurate; STELARA® is medically necessary for this patient; I have prescribed STELARA® to the patient; the decision to prescribe STELARA® was based solely on my independent medical judgment; and I am authorized under state law to prescribe STELARA®, have reviewed and signed the prescription, and have otherwise lawfully complied with prescribing requirements under applicable laws and regulations. I will be supervising the patient's treatment, and I have reviewed the current STELARA® prescribing information. Further, I certify that I have reviewed this form with my patient, and that the patient would like to be screened for eligibility for STELARA withMe (the "Program") support offerings, and enrolled, as applicable, in such support if eligible.

I understand that my patient's information provided to Johnson & Johnson is for the use of the Program solely to verify my patient's insurance coverage; to facilitate the filling of my patient's prescription; to assess my patient's eligibility for the Program offerings and other support programs; and to otherwise administer the Program for the patient. I certify that I am disclosing the patient's protected health information ("PHI") on this form to the Program for treatment, payment, or healthcare operations purposes, in accordance with the requirements under the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, as amended ("HIPAA"). Additionally, I certify that I have obtained the patient's written consent or authorization in accordance with applicable state and federal law, including HIPAA, to provide the PHI on this form to the Program for the purposes set forth here.

I authorize the Program to conduct a benefits investigation for my patient and to act on my behalf for the limited purpose of transmitting this prescription to the appropriate pharmacy based on the results of that benefits investigation. If coverage is available, the Program is authorized to transmit this prescription to a commercial pharmacy based on the patient's health plan requirements unless patient expresses a preference for a different pharmacy.

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