imaavy withMe | imaavy (nipocalimab-aahu)

# Patient Enrollment Form

UPDATE 08.26

**Complete and fax this form to 877-332-1228. All fields are required unless marked optional. Please see Consents and Certifications on page 2 for full details.**
**For assistance, prescribers can call 844-4withMe (844-494-8463), Monday–Friday, 8:00 AM–8:00 PM ET.**

▼ TO BE COMPLETED BY PATIENT AND PROVIDER ▼

## 1. Patient 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 IMAAVY 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 2 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 IMAAVY 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 2 for full details.

## 3. Insurance Information

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

☐ **The patient has no insurance.**

**MEDICAL INSURANCE** _____ POLICY # _____ GROUP # _____

CARDHOLDER _____

▼ TO BE COMPLETED BY PROVIDER ▼

## 4. Clinical Information

### IMAAVY—Diagnosis

SELECT ONE: ☐ G70.00 Myasthenia Gravis without (acute) exacerbation ☐ G70.01 Myasthenia Gravis with (acute) exacerbation ☐ D59.11 Warm Autoimmune Hemolytic Anemia ☐ Other ICD-10 Code _____

PATIENT WEIGHT _____ kg

Estimated Treatment Start Date (MM/DD/YYYY) _____

## 5. Prescriber Information

PRESCRIBER NAME (First, Last) _____

OFFICE CONTACT (optional) _____

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

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

EMAIL _____ PHONE _____ FAX _____

## 6. Prescription Information (Check all boxes that apply.)

### Generalized Myasthenia Gravis (gMG):

**Initial Dose:**
☐ 30 mg/kg administered via IV infusion over at least 30 minutes

**Maintenance Doses:**
☐ 15 mg/kg administered via IV infusion over at least 15 minutes every 2 weeks thereafter Refill # _____

### Warm Autoimmune Hemolytic Anemia (wAIHA):

**Initial Dose:**
☐ 30 mg/kg administered via IV infusion over at least 30 minutes

**Subsequent Doses:**
☐ 30 mg/kg administered via IV infusion over at least 15 minutes every 4 weeks thereafter Refill # _____

**Ship to Infusion Site: (ONLY REQUIRED IF DIFFERENT FROM PRESCRIBER'S OFFICE. Shipments cannot be sent to PO boxes.)**

☐ Nonprescriber's Office ☐ Hospital Outpatient ☐ Infusion Center ☐ Other

PHYSICIAN OR INFUSION PROVIDER NAME _____ OFFICE CONTACT NAME _____

PRACTICE/FACILITY NAME _____ NPI # _____ TAX ID # _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

PHONE _____ FAX _____

**PRESCRIBER SIGNATURE(S) (NO STAMPS ALLOWED) REQUIRED TO VALIDATE PRESCRIPTION: I certify that therapy with IMAAVY is medically necessary for this patient. I will be supervising the patient's treatment accordingly, and I have reviewed the current IMAAVY Prescribing Information. By signing below, I authorize the Access Therapy Center (Johnson & Johnson's affiliated, noncommercial dispensing 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.**

**IMAAVY 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. I understand that once the prescription is approved, it will triage to the appropriate pharmacy. See program descriptions, program links, and Prescriber Certifications on page 2.

PRESCRIBER SIGNATURE (Dispense as written) _____ DATE _____

**Please read the full Prescribing Information and Medication Guide for IMAAVY.**

© Johnson & Johnson and its affiliates 2026 

Clear Form Print Form

imaavy withMe | imaavy (nipocalimab-aahu)

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

### Patient Consents and Certifications

**Enrolling in IMAAVY withMe.** I am enrolling in IMAAVY withMe (the "Program"), 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 IMAAVY withMe Savings Program. To learn more, visit **IMAAVYwithMeSavings.com**.

(ii) **IMAAVY withMe Nurse Navigator Outreach:** The Program provides eligible patients age 18 and older and caregivers of eligible pediatric patients with a dedicated Nurse Navigator for support at no cost. Nurse Navigators do not provide medical advice. Please ask your doctor any questions you might have about your disease and treatment.

(iii) **IMAAVY withMe Access Program:** If patient's commercial insurance coverage for IMAAVY has been delayed or denied, eligible patients can receive medicine at no cost for up to 3 years or until their insurance covers the medicine. To learn more, visit **IMAAVYwithMeAccess.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 receive medicine at no cost from the IMAAVY withMe Access Program or participate in the IMAAVY withMe Savings Program, I certify that I will not seek payment for the value received, or 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 or the patient's (if pediatric patient) personal health data, 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** and, if applicable, is used to dispense my/the patient's prescription by its affiliated, noncommercial dispensing pharmacy, Access Therapy Center ("Pharmacy"), in accordance with its **Notice of Privacy Practices**.

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, including refill reminders and Rx notifications and, if I indicate my agreement and consent in Section 2, information about IMAAVY, 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, including refill reminders and Rx notifications. 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; IMAAVY is medically necessary for this patient; I have prescribed IMAAVY to the patient; the decision to prescribe IMAAVY was based solely on my independent medical judgment; and I am authorized under state law to prescribe IMAAVY, 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 IMAAVY 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 IMAAVY withMe (the "Program") support offerings and the Johnson & Johnson Patient Assistance Program, 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. If coverage is not available and the patient qualifies for and enrolls in either the IMAAVY withMe Access Program or the Johnson & Johnson Patient Assistance Program to receive product at no cost, the Program is authorized to transmit this prescription to a pharmacy that dispenses product at no cost under those programs. I also understand that no request for reimbursement for product at no cost may be submitted to any payer, including Medicare and Medicaid, and that no product at no cost may be sold, traded, or distributed for sale. I consent to Johnson & Johnson contacting me by fax, mail, or email to provide additional information about IMAAVY or the Program. I understand that the Program may revise, change, or terminate any program offerings or resources at any time without notice to me.

### Johnson & Johnson Patient Assistance Program

Patient assistance from Johnson & Johnson 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 eligibility and income requirements for the Johnson & Johnson Patient Assistance Program. See terms and conditions at **PatientAssistance.com/IMM**.

Patients who are being enrolled in the Johnson & Johnson Patient Assistance Program must submit a Patient Consent Form. This required form can be submitted electronically and signed by the patient online at **JJPatientAssistance.com/Consent**.

To complete enrollment, a prescription is required. Please complete Section 6 on page 1.

**Please read the full Prescribing Information and Medication Guide for IMAAVY.**

© Johnson & Johnson and its affiliates 2026 

Johnson&Johnson