Janssen CarePath

UPDATE 10.23

Benefits Investigation and Enrollment Form

Simponi ARIA golimumab for infusion | Remicade INFLIXIMAB | Infliximab

Complete and fax this Form to 866-489-5955 or mail to 2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560.
For assistance, call 877-CarePath (877-227-3728), Monday–Friday, 8:00 AM–8:00 PM, ET

Janssen CarePath cannot accept any information without an executed Business Associate Agreement or Patient Authorization Form, which can be found at JanssenCarePath.com or as the last two pages of this document.

The information you provide will be used by Janssen Biotech, Inc., our affiliates, and our service providers for your patient's enrollment and participation in Janssen CarePath.
Our **Privacy Policy** governs the use of the information you provide. By submitting this form, you indicate that you read, understand, and agree to these terms.

1. PATIENT INFORMATION (REQUIRED)

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

DOB (MM/DD/YYYY) _____ ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____ E-MAIL _____

CELL PHONE _____ HOME PHONE _____ WORK PHONE _____

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

2. INSURANCE INFORMATION (REQUIRED. Include alpha prefix and suffix with policy and group# when applicable 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 yrs; student >18 yrs)? Check if yes.

3. PRESCRIBER INFORMATION (REQUIRED)

PRESCRIBER NAME (First, Last) _____

SPECIALTY _____

PRACTICE NAME _____ OFFICE CONTACT _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

E-MAIL _____ 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 AUTHORIZATION (Please check the appropriate box[es] below to request assistance with prior authorizations)

☐ **Prior Authorization Form Assistance** By checking this box, I request that Janssen CarePath assist my office in providing the requirements of this patient's health plan related to prior authorization for treatment with the medication specified. I understand that assistance includes obtaining the health plan-specific prior authorization Form, and providing it based upon the patient-specific information provided on this Form. I understand that the partially completed prior authorization Form will be provided to my office by Janssen CarePath for possible completion and submission in the office's sole discretion.

☐ **Prior Authorization Status Monitoring** By checking this box, I request that Janssen CarePath actively monitor the status of the prior authorization submission. I request that Janssen CarePath provide status updates to my office with respect to this patient's prior authorization for treatment with the medication specified.

5. 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 _____

6. CLINICAL INFORMATION (REQUIRED. Visit JanssenCarePath.com for ICD-10 codes or consult the ICD-10 code book for additional information)

☐SIMPONI ARIA®

DIAGNOSIS CODE _____ INDICATION _____

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

DOSAGE/FREQUENCY: 2 mg/kg at weeks 0 and 4, and every 8 weeks thereafter # OF VIALS TO BE USED _____

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

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

DOSAGE/FREQUENCY: 80 mg/m^2 at weeks 0 and 4, and every 8 weeks thereafter

The dosage regimen is based on the patient's body surface area (BSA). # OF VIALS TO BE USED _____

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

☐REMICADE® or ☐Infliximab

DIAGNOSIS CODE _____ INDICATION _____

DOSAGE/FREQUENCY: _____ # OF VIALS TO BE USED _____

ANTICIPATED # OF INFUSIONS _____ NUMBER OF PRIOR INFUSIONS WITH THE MEDICATION SPECIFIED ☐unknown ☐0 ☐1-3 ☐4+

■ Additional Clinical Information

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

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

7. 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.
Provide the appropriate Medication Guide to your patients and encourage discussion.

  10/23 cp-07464v6

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 is not for patients in the Johnson & Johnson Patient Assistance Foundation.

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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, 2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560**
- **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, 2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560.

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:

_____

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