NOTE: PLEASE READ THE PATIENT ELIGIBILITY REQUIREMENTS ON THE NEXT PAGE PRIOR TO COMPLETING THIS FORM.

Janssen CarePath

Savings Program
2022/2023 Patient Enrollment Form

Remicade® INFLIXIMAB | Infliximab

*Required

*SELECT ONE: ☐ Enrollment ☐ Update Information Only

Phone: 877-CarePath (877-227-3728) Fax: 877-234-3048 MyJanssenCarePath.com

PATIENT INFORMATION (*Required)

*Do you have a REMICADE® and Infliximab Mastercard®? ☐ Yes ☐ No If yes, provide 11-digit ID number at bottom of card: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

*NAME ______________________ *GENDER ☐ Male ☐ Female *DATE OF BIRTH (MM/DD/YYYY) ______________

*ADDRESS ______________________ *CITY ______________ *STATE ______ *ZIP CODE __________

*PRIMARY PHONE (Best number to call 8:00 AM–8:00 PM ET, weekdays) ______________ E-MAIL ______________

*If you're unavailable when we call, is it ok for us to leave a message including the name of your medication? ☐ Yes ☐ No

Your rebate will be applied to a REMICADE® and Infliximab Mastercard to pay for your medication at your treatment provider or pharmacy. This card is not a credit card. There is no charge for this card. If your treatment provider or pharmacy DOES NOT ACCEPT the REMICADE® and Infliximab Mastercard, please call 877-CarePath (877-227-3728), Monday through Friday, 8:00 AM–8:00 PM ET, to discuss alternate payment options.

*1. Do you have commercial or private health insurance that you will use for your Janssen medication? Examples are commercial insurance from a former/current employer, government employee health insurance, or insurance you buy privately or through the Health Insurance Marketplace.

- ☐ Yes, I have commercial or private health insurance that I will use for my Janssen medication
- ☐ No, I do not have commercial or private health insurance that I will use for my Janssen medication

*2. Do you agree NOT to ask any government-funded healthcare program to cover any of the Janssen medication costs? Examples are Medicare Parts A, B, C (also known as Medicare Advantage Plan), D, and Medicare Supplement, Medicaid, TRICARE, Department of Defense, or Veterans Administration.

- ☐ Yes, I agree that I will NOT seek payment from any government-funded healthcare program for my Janssen medication
- ☐ No, I may seek payment from a government-funded healthcare program for my Janssen medication

*3. Do you agree NOT to submit any costs paid by this program as a claim for payment to any health plan, patient assistance foundation, flexible spending account, or healthcare savings account?

- ☐ Yes, I agree that I will NOT submit any costs paid by this program as a claim
- ☐ No, I may submit costs paid by this program as a claim

I understand that if I am using medical/primary insurance to pay for my Janssen medication, I am responsible for submitting a rebate request including an Explanation of Benefits (EOB) to receive payment following each treatment. At my direction, my provider may submit the rebate request on my behalf. I will coordinate with my provider who will submit the rebate request. The Program will use the information my provider or I submit to determine the amount of costs for REMICADE® or Infliximab that Janssen Biotech, Inc., will reimburse. That amount will be credited to my REMICADE® and Infliximab Mastercard. I further understand that if my provider or I do not submit an EOB or pharmacy receipt, the Program cannot process my rebate request. I understand that I can use my Savings Program card for instant savings if REMICADE® or Infliximab is obtained from a pharmacy and that if the pharmacy is unable to process my Savings Program card, I will receive a rebate by submitting my pharmacy receipt. I understand that if a pharmacy provides REMICADE® or Infliximab to my treatment provider, and can accept REMICADE® and Infliximab Mastercard, the rebate for REMICADE® or Infliximab will be credited to my REMICADE® and Infliximab Mastercard to pay for REMICADE® or Infliximab at the pharmacy. By participating in the Savings Program, I am giving permission for information related to my Savings Program transactions, including rebates and any funds placed on or balance remaining on the Savings Program card, to be shared with my healthcare provider(s).

I understand that I can cancel participation in the Program at any time by notifying Janssen CarePath at 877-CarePath (877-227-3728). Our **Privacy Policy** governs the use of the information you provide. I understand that, if I am enrolled in the Program, Janssen Biotech, Inc., will not be responsible for lost or stolen cards or for any misuse of these cards.

YOUR PRESCRIBER (*Required)

*PRESCRIBER NAME ______________ *PRACTICE NAME ______________

*ADDRESS ______________ *CITY ______________ *STATE ______ *ZIP CODE ______

*PHONE # ______________ *OFFICE–MAIN FAX # ______________

TREATMENT PROVIDER INFORMATION (This section does not need to be completed if information is the same as "YOUR PRESCRIBER")

NAME OF PHYSICIAN ______________ OFFICE/HOSPITAL/OTHER NAME ______________

ADDRESS ______________ CITY ______________ STATE ______ ZIP CODE ______

PHONE # ______________ OFFICE–MAIN FAX # ______________

☐ Non-prescribing MD's Office ☐ Hospital Outpatient ☐ Home Treatment/Treatment Provider Company ☐ Other

Fax or mail completed enrollment Form to: Fax: 877-234-3048 Mail: Janssen CarePath Savings Program, 2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560

My signature below certifies that I have completed all of the above sections completely, accurately, and to the best of my knowledge. I understand, accept, and comply with all requirements and restrictions described in the eligibility requirements provided on the next page and I understand that redeeming this benefit is consistent with the requirements of my health plan.

PATIENT SIGNATURE ______________ DATE ______________ PATIENT NAME ______________ (Please print)

If the patient cannot sign, patient's personal representative must sign below

PATIENT NAME ______________ BY ______________ (Signature of person signing for patient)

RELATIONSHIP TO PATIENT AND AUTHORITY TO MAKE MEDICAL DECISIONS FOR PATIENT ______________

Please read the full Prescribing Information, including Boxed Warning, and Medication Guides for REMICADE® and Infliximab, and discuss any questions you have with your doctor.

For assistance or additional information, call 877-CarePath (877-227-3728), Monday–Friday, 8:00 AM–8:00 PM ET

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Patient Eligibility Requirements for Janssen CarePath Savings Program

You may be eligible for the Janssen CarePath Savings Program if you are age 6 or older and currently use commercial or private health insurance for REMICADE® (infliximab) or Infliximab. There is no income requirement. Janssen CarePath Savings Program for REMICADE® and Infliximab is based on medication costs only and does not include costs to give you your treatment.

Other Requirements:

- **This program is only for people age 6 or older using commercial or private health insurance for their Janssen medication. This includes plans from the Health Insurance Marketplace.** This program is not for people who use any state or federal government-funded healthcare program. Examples of these programs are Medicare, Medicaid, TRICARE, Department of Defense, and Veterans Administration.
- You may not seek payment for the value received from this program from any health plan, patient assistance foundation, flexible spending account, or healthcare savings account.
- You must meet the program requirements every time you use the program.
- Program terms will expire at the end of each calendar year. The program may change or end without notice, including in specific states.
- To use this program, you must follow any health plan requirements, including telling your health plan how much co-payment support you get from this program. By getting a Savings Program benefit, you confirm that you have read, understood, and agree to the program requirements on this page, and you are giving permission for information related to your Savings Program transactions to be shared with your healthcare provider(s). These transactions include rebates and any funds placed on the card or balance remaining on the card.
- Before you activate your card, you will be asked to provide personal information that may include your name, address, phone number, email address, and information related to your prescription medication insurance and treatment. This information is needed for Janssen Biotech, Inc., the maker of REMICADE® and Infliximab, and our service providers to enroll you in the Janssen CarePath Savings Program. We may also use the information you give us to learn more about the people who use REMICADE® or Infliximab, and to improve the information we give them. Janssen Biotech, Inc., will not share your information with anyone else except where legally allowed.
- If you use medical/primary insurance to pay for your medication, you need to submit a rebate request with an Explanation of Benefits (EOB) to get payment from the Savings Program. With your permission, your provider may submit the rebate request and EOB for you. Please make sure you and your provider know who will submit the rebate request.
- 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.

You may end your participation in Janssen CarePath at any time by calling 877-CarePath.

3 ways to enroll: Review the program requirements above, then choose the enrollment option you prefer:

Online:
MyJanssenCarePath.com

Phone:
877-CarePath (877-227-3728)

Form:
Complete and sign the previous page of this Form, and fax or mail to:
Fax: 877-234-3048 **OR** Mail: Janssen CarePath Savings Program
2250 Perimeter Park Drive, Suite 300
Morrisville, NC 27560

NOTE: Your signature on the previous page of this Form certifies:

- That you understand, accept, and comply with all requirements described above, and that your participation in the Program is consistent with the requirements of your health plan.

Janssen Biotech, Inc., is not liable for unintended or unauthorized use of the REMICADE® and Infliximab Mastercard if it is lost or stolen. The Janssen CarePath Savings Program for REMICADE® and Infliximab Prepaid Mastercard is issued by Pathward, N.A., Member FDIC, pursuant to license by Mastercard International Incorporated. Mastercard and the circles design are registered trademarks of Mastercard International Incorporated. Janssen CarePath Savings Program is not a Pathward or Mastercard product or service, nor is the optional offer endorsed by them.

Please read the full Prescribing Information, including Boxed Warning, and Medication Guides for REMICADE® and Infliximab, and discuss any questions you have with your doctor.

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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 the 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 877-234-3048 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

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Janssen Patient Support Program
Patient Authorization Form

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. 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 my Healthcare Providers may be paid by Janssen for sharing my Protected Health Information with Janssen 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: ______________________________ **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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