Janssen CarePath

RYBREVANT® (amivantamab-vmjw)
Injection for IV Use | 350 mg/7 mL (50 mg/mL)

Help your patients manage their Savings Program Benefits

The patient is responsible for submitting a rebate request to the Janssen CarePath Savings Program or, at the patient's direction, the provider may submit the rebate request on behalf of the patient. Confirm with your patient who will submit rebate requests to the Savings Program. Rebate requests must be submitted within 270 days of the date of service.

If the patient is submitting a rebate request:

- Patient will need to submit a copy of their Explanation of Benefits (EOB) from their primary insurance provider (as well as any secondary insurance provider, if applicable) and a receipt from their treatment provider indicating proof of payment of their out-of-pocket Janssen medication costs
- Patients may submit rebate requests to the Savings Program via their Patient Account, or by fax or mail

If the provider is submitting a rebate request on behalf of the patient:

- At your patient's request, you may submit rebate requests to the Janssen CarePath Savings Program on their behalf. You may also receive payment directly if your patient has a Patient Assignment of Benefits (AOB) consent on file
- Please ensure that your patient has completed an AOB form and that you have faxed the AOB form to the fax number found on the form, in order for Janssen CarePath to process a rebate claim and provide payment directly to your site. The AOB form can be found at JanssenCarePath.com/hcp/Rybrevant or by calling Janssen CarePath at 877-CarePath (877-227-3728)

Submitting a primary claim:

To submit a **primary claim** on behalf of the patient, providers must submit a CMS-1500 (HICF) or Uniform Billing Form—CMS-1450 (UB-04)—**through their electronic billing system**.

Submitting a secondary claim:

1. If you have submitted a primary claim and the claim has a remaining balance of $5 or more, you may submit a secondary claim.
   - Before you get started, contact your clearinghouse to request that Payer ID# 56155 be added to their system, if needed
2. Submit **secondary claim** to the Janssen CarePath Savings Program using CMS-1500 or UB-04 medical claim forms or electronic versions 837P or 837I (electronic submission is preferred).
   - You will need to submit the primary payer EOB along with the secondary claim form
   - To complete the form, you will need the patient's Janssen CarePath Savings Program Member ID, Group# 00003651, and Payer ID# 56155
   - You will receive funds for approved claims by check, which will include information on setting up future payments via electronic funds transfer (EFT), if preferred
     - NOTE: If you already receive funds via EFT, you will continue to receive payments that way

See following pages for sample CMS-1500 and UB-04 claim forms with additional information.

Please read full Prescribing Information for RYBREVANT®.

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Sample CMS-1500 Claim Form
for Billing in the Physician Office

1 Insured's ID Number
Enter the Janssen CarePath Savings Program Member number

2 Insured's Name
Enter the patient's name, even if patient is not the policyholder

3 Procedures, Services, or Supplies
Enter the NDC number in the shaded area and enter the appropriate J-Code, S-Code, or G-Code

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1) **1** 12345A67B
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, John B.	3. PATIENT'S BIRTH DATE MM 07 DD 01 YY 70 SEX M X F
	4. INSURED'S NAME (Last Name, First Name, Middle Initial) **2** Doe, John B.
5. PATIENT'S ADDRESS (No., Street) 3914 Spruce Street	6. PATIENT RELATIONSHIP TO INSURED Self X Spouse Child Other
	7. INSURED'S ADDRESS (No., Street) 3914 Spruce Street
CITY Anytown STATE AS	8. RESERVED FOR NUCC USE
	CITY Anytown STATE AS
ZIP CODE 01010 TELEPHONE (Include Area Code) (203) 555-1234	ZIP CODE 01010 TELEPHONE (Include Area Code) (203) 555-1234
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES NO
	a. INSURED'S DATE OF BIRTH MM DD YY SEX M F
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES NO PLACE (State)
	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES NO
	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)
	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY
	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Johns	17a. 17b. NPI 123 456 7890
	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) RYBREVANT® (amivantamab-vmjw) 2 mg injection	20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. A. C34.30 B. C. D. E. F. G. H. I. J. K. L.	22. RESUBMISSION CODE ORIGINAL REF. NO.
	23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 04 01 24 04 01 24	11		**3** 57894-0501-01 J9061		A		525		NPI	123 456 7890
2 04 01 24 04 01 24	11		96413		A		1		NPI	123 456 7890
3 04 01 24 04 01 24	11		96415		A		3		NPI	123 456 7890
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE $	29. AMOUNT PAID $ / 30. Rsvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION a. b.		33. BILLING PROVIDER INFO & PH # (203) 987-6543 Dr. Jones 4231 Center Road Anytown, AS 01010 a. 123 456 7890 b.	

NUCC Instruction Manual available at: www.nucc.org *PLEASE PRINT OR TYPE* OMB APPROVAL PENDING

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NOTE:
Fill out the remainder of the CMS-1500 claim form the same way you would for a typical secondary claim submission. Please make sure the claim documentation clearly states the CPT/J-Code or S-Code and the NDC and/or drug name. For payers that require the G-Codes, enter the applicable code based on the dose of RYBREVANT®.

Use of the electronic version of the CMS-1500 (837P) is preferred.

Please read full Prescribing Information for RYBREVANT®.

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Sample UB-04 Claim Form

for Billing in the Hospital Outpatient Department (HOPD)

1 Value Codes
Enter "PR2" under "Code" and enter the remaining patient responsibility after processing of the primary insurance claim under "Amount"

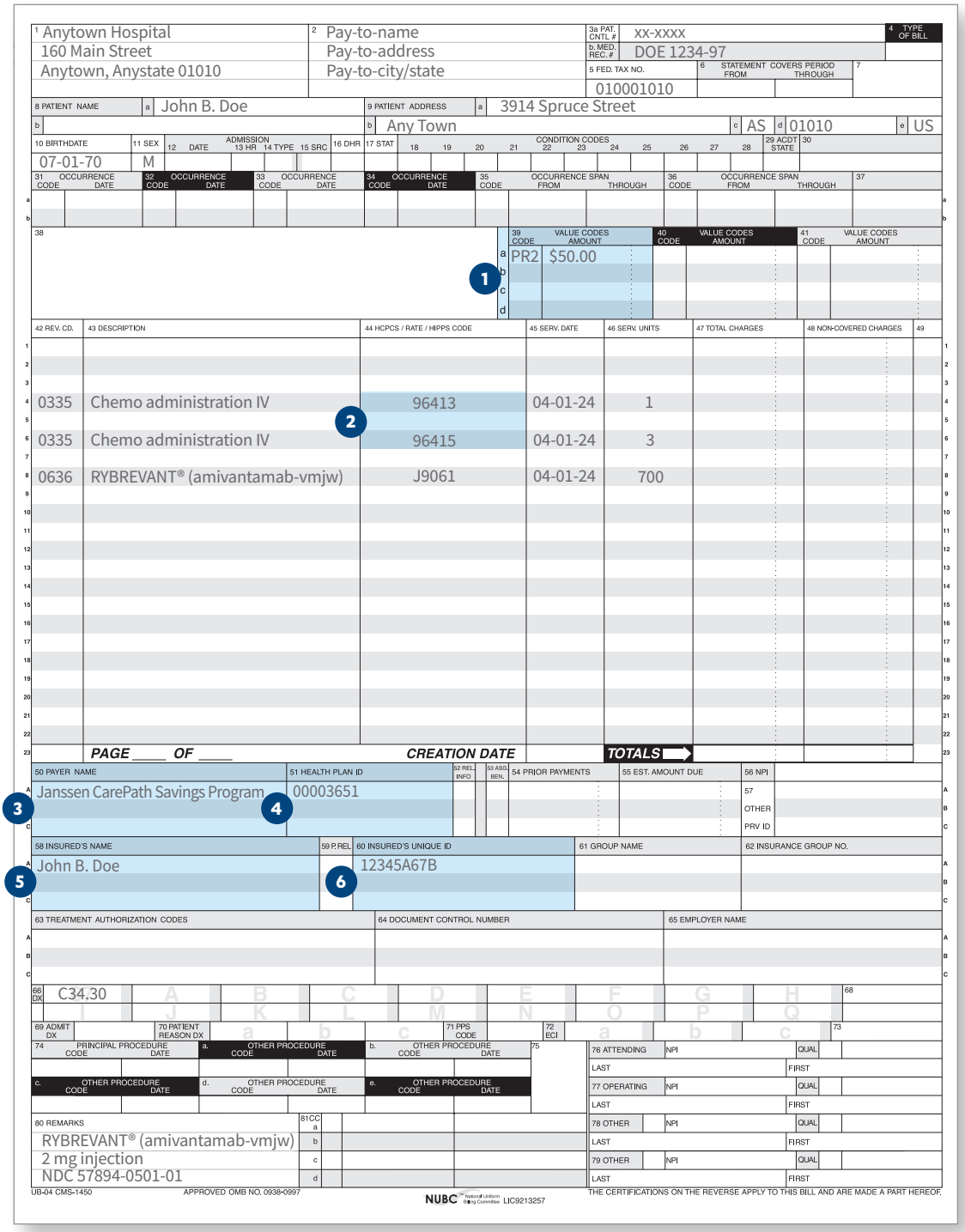
2 HCPCS/Rate/HIPPS Code
Enter the appropriate J-Code, S-Code, or G-Code

3 Payer Name
Enter "Janssen CarePath Savings Program"

4 Health Plan ID
Enter the Group number: 00003651

5 Insured's Name
Enter the patient's name, even if patient is not the policyholder

6 Insured's Unique ID
Enter the Janssen CarePath Savings Program Member number



NOTE:
Fill out the remainder of the UB-04 claim form the same way you would for a typical secondary claim submission. Please make sure the claim documentation clearly states the CPT/J-Code or S-Code and the NDC and/or drug name. For payers that require the G-Codes, enter the applicable code based on the dose of RYBREVANT®.

Use of the electronic version of the UB-04 (837I) is preferred.

If you have questions about payment processing, call us at 877-CarePath (877-227-3728).

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We can help make it simple for you to help your patients

Access support
to help navigate payer processes

Affordability support
to help your patients start and stay on the Janssen medication you prescribe

Treatment support
to help your patients get informed and stay on prescribed treatment

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Single, dedicated Care Coordinator team supporting you and your patients

Convenient online Provider Portal at JanssenCarePathPortal.com

With an executed BAA or individual patient authorization on file, you can:

- Request benefits investigations and prior authorizations electronically
- Track and monitor status of benefits investigations and prior authorizations for your patients
- Enroll your eligible, commercially insured patients in the Savings Program, submit Savings Program requests, and manage program benefits
- Receive notifications when new information is available or action is required on the Portal

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Need help?
Call **877-CarePath** (877-227-3728)
Monday–Friday, 8:00 AM–8:00 PM ET
Multilingual phone support available

Sign up or log in to the Provider Portal at **JanssenCarePathPortal.com**

Visit us online **JanssenCarePath.com/hcp/Rybrevant**

Please read full Prescribing Information for RYBREVANT®.

Janssen
PHARMACEUTICAL COMPANIES OF
Johnson & Johnson