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

Stelara withMe

Savings Program
2023/2024 Patient Enrollment Form

Stelara® (ustekinumab)

*Required

*SELECT ONE: ☐ Enrollment ☐ Update Information Only

Phone: 844-4withMe (844-494-8463) Fax: 844-250-7193 MyJanssenCarePath.com

PATIENT INFORMATION (*Required)

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

*NAME _____ *Sex assigned at birth ☐ 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? ☐ Yes ☐ No *If yes, is it ok to mention the name of your medication? ☐ Yes ☐ No

Your rebate will be applied to a STELARA® 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 STELARA® Mastercard, please call 844-4withMe (844-494-8463), 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 STELARA® that Janssen Biotech, Inc., will reimburse. That amount will be credited to my STELARA® 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 STELARA® 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 STELARA® to my treatment provider, and can accept STELARA® Mastercard, the rebate for STELARA® will be credited to my STELARA® Mastercard to pay for STELARA® at the pharmacy. By participating in the STELARA withMe Savings Program via Janssen CarePath, 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 my participation in the Savings Program at any time by notifying STELARA withMe at 844-4withMe (844-494-8463). Our Privacy Policy governs the use of the information you provide. I understand that, if I am enrolled in the Savings 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: 844-250-7193 Mail: STELARA withMe 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 reverse side and I understand that redeeming this benefit is consistent with the requirements of my health plan.

PATIENT SIGNATURE _____ DATE _____ PATIENT NAME _____

If the patient cannot sign, patient's personal representative must sign below (Please print)

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 and Medication Guide for STELARA® and discuss any questions you have with your doctor.

For assistance or additional information, call 844-4withMe (844-494-8463), Monday–Friday, 8:00 AM–8:00 PM ET

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Patient Eligibility Requirements for STELARA withMe Savings Program

You may be eligible for the STELARA withMe Savings Program if you are age 6 and older, use commercial or private health insurance for STELARA® (ustekinumab), and must pay an out-of-pocket cost for your medication. There is no income requirement. STELARA withMe Savings Program 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 and 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 at the time of each Savings Program request.
- Program terms will expire at the end of each calendar year. The program may change or end without notice, including in specific states.
- Patients who are members of health plans (often termed "maximizer" or "optimizer" programs) that claim to reduce or eliminate their patients' out-of-pocket co-pay, co-insurance, or deductible obligations for certain prescription drugs based upon the availability of, or patient's enrollment in, manufacturer sponsored co-pay assistance for such drugs will have a $6,000 annual maximum program benefit per calendar year (not applicable to patients in Maine). If you have enrolled in one of these plans, please inform STELARA withMe at 844-4withMe (844-494-8463).
- 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 STELARA®, and our service providers to enroll you in the STELARA withMe Savings Program. We may also use the information you give us to learn more about the people who use STELARA®, 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 the STELARA withMe Savings Program at any time by calling 844-4withMe (844-494-8463).

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

Online:
MyJanssenCarePath.com

Phone:
844-4withMe (844-494-8463)

Form:
Complete and sign the reverse side of this form, and fax or mail to:
Fax: 844-250-7193 **OR** Mail: STELARA withMe Savings Program
2250 Perimeter Park Drive, Suite 300
Morrisville, NC 27560

- STELARA withMe is limited to education about STELARA®, its administration, and/or the condition it treats. It is not intended to provide medical advice, replace a treatment plan you receive from your doctor or nurse, or serve as a reason for you to start or stay on treatment.

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.

Please read the full Prescribing Information and Medication Guide for STELARA® 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 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 844-250-7193 or mailed to STELARA withMe, 2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560**

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 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: STELARA withMe, 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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