Janssen CarePath

Completing the Patient Enrollment Form

Helping you help your patients get started with the Janssen medication you prescribed

Please see full Prescribing Information, including Boxed WARNING, for INVEGA SUSTENNA®, INVEGA TRINZA®, and RISPERDAL CONSTA®.

Janssen CarePath

Completing the Patient Enrollment Form (PEF)

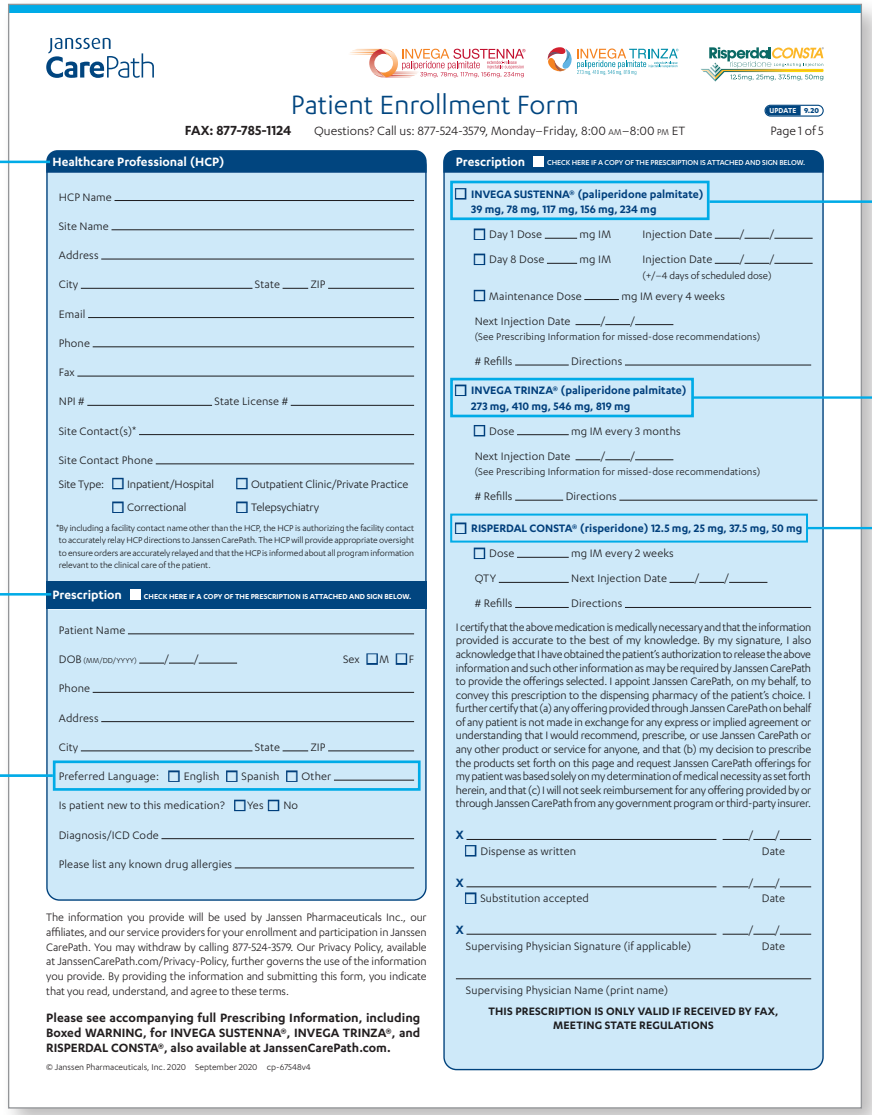
Once a treatment decision has been made to prescribe INVEGA SUSTENNA®, INVEGA TRINZA®, or RISPERDAL CONSTA®, use the PEF to provide information about your patient and your office to request Janssen CarePath to support therapy with INVEGA SUSTENNA®, INVEGA TRINZA®, or RISPERDAL CONSTA®.

Healthcare Professional (HCP)

- Provide all required contact information
- List Site Contact authorized to relay HCP orders to Janssen CarePath
- List accurate fax number where patient Verification of Benefits will be sent

Prescription

- Please provide all required patient information, including date of birth
- Check the appropriate box to indicate patient's language preference
- Include Diagnosis/ICD-10 Code
- Completely fill out all required prescription information



Janssen CarePath

INVEGA SUSTENNA® paliperidone palmitate 39mg, 78mg, 117mg, 156mg, 234mg

INVEGA TRINZA® paliperidone palmitate 273mg, 410mg, 546mg, 819mg

RisperdalCONSTA® risperidone Long-Acting Injection 12.5mg, 25mg, 37.5mg, 50mg

Patient Enrollment Form

UPDATE 9.20

FAX: 877-785-1124 Questions? Call us: 877-524-3579, Monday–Friday, 8:00 AM–8:00 PM ET Page 1 of 5

Healthcare Professional (HCP)

HCP Name _____

Site Name _____

Address _____

City _____ State ____ ZIP _____

Email _____

Phone _____

Fax _____

NPI # _____ State License # _____

Site Contact(s)* _____

Site Contact Phone _____

Site Type: ☐ Inpatient/Hospital ☐ Outpatient Clinic/Private Practice ☐ Correctional ☐ Telepsychiatry

*By including a facility contact name other than the HCP, the HCP is authorizing the facility contact to accurately relay HCP directions to Janssen CarePath. The HCP will provide appropriate oversight to ensure orders are accurately relayed and that the HCP is informed about all program information relevant to the clinical care of the patient.

Prescription ☐ CHECK HERE IF A COPY OF THE PRESCRIPTION IS ATTACHED AND SIGN BELOW.

Patient Name _____

DOB (MM/DD/YYYY) ____/____/_____ Sex ☐M ☐F

Phone _____

Address _____

City _____ State ____ ZIP _____

Preferred Language: ☐ English ☐ Spanish ☐ Other _____

Is patient new to this medication? ☐Yes ☐ No

Diagnosis/ICD Code _____

Please list any known drug allergies _____

The information you provide will be used by Janssen Pharmaceuticals Inc., our affiliates, and our service providers for your enrollment and participation in Janssen CarePath. You may withdraw by calling 877-524-3579. Our Privacy Policy, available at JanssenCarePath.com/Privacy-Policy, further governs the use of the information you provide. By providing the information and submitting this form, you indicate that you read, understand, and agree to these terms.

Please see accompanying full Prescribing Information, including Boxed WARNING, for INVEGA SUSTENNA®, INVEGA TRINZA®, and RISPERDAL CONSTA®, also available at JanssenCarePath.com.

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Prescription ☐ CHECK HERE IF A COPY OF THE PRESCRIPTION IS ATTACHED AND SIGN BELOW.

☐ **INVEGA SUSTENNA® (paliperidone palmitate) 39 mg, 78 mg, 117 mg, 156 mg, 234 mg**

☐ Day 1 Dose ____ mg IM Injection Date ____/____/_____

☐ Day 8 Dose ____ mg IM Injection Date ____/____/_____ (+/–4 days of scheduled dose)

☐ Maintenance Dose ____ mg IM every 4 weeks

Next Injection Date ____/____/_____ (See Prescribing Information for missed-dose recommendations)

Refills _____ Directions _____

☐ **INVEGA TRINZA® (paliperidone palmitate) 273 mg, 410 mg, 546 mg, 819 mg**

☐ Dose _____ mg IM every 3 months

Next Injection Date ____/____/_____ (See Prescribing Information for missed-dose recommendations)

Refills _____ Directions _____

☐ **RISPERDAL CONSTA® (risperidone) 12.5 mg, 25 mg, 37.5 mg, 50 mg**

☐ Dose _____ mg IM every 2 weeks

QTY _____ Next Injection Date ____/____/_____

Refills _____ Directions _____

I certify that the above medication is medically necessary and that the information provided is accurate to the best of my knowledge. By my signature, I also acknowledge that I have obtained the patient's authorization to release the above information and such other information as may be required by Janssen CarePath to provide the offerings selected. I appoint Janssen CarePath, on my behalf, to convey this prescription to the dispensing pharmacy of the patient's choice. I further certify that (a) any offering provided through Janssen CarePath on behalf of any patient is not made in exchange for any express or implied agreement or understanding that I would recommend, prescribe, or use Janssen CarePath or any other product or service for anyone, and that (b) my decision to prescribe the products set forth on this page and request Janssen CarePath offerings for my patient was based solely on my determination of medical necessity as set forth herein, and that (c) I will not seek reimbursement for any offering provided by or through Janssen CarePath from any government program or third-party insurer.

X _____ ____/____/_____

☐ Dispense as written Date

X _____ ____/____/_____

☐ Substitution accepted Date

X _____ ____/____/_____

Supervising Physician Signature (if applicable) Date

Supervising Physician Name (print name)

THIS PRESCRIPTION IS ONLY VALID IF RECEIVED BY FAX, MEETING STATE REGULATIONS

Prescription (cont.)

- Check the appropriate box for INVEGA SUSTENNA®, INVEGA TRINZA®, or RISPERDAL CONSTA®
- Provide dose, injection date, and number of refills

DON'T FORGET! HCP must sign and date, even if a prescription is attached.

Important: To ensure the patient's Verification of Benefits is provided in a timely manner, please complete ALL required fields highlighted in **BLUE.**

Please see full Prescribing Information, including Boxed WARNING, for INVEGA SUSTENNA®, INVEGA TRINZA®, and RISPERDAL CONSTA®.

Janssen CarePath

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INVEGA TRINZA® paliperidone palmitate extended-release injectable suspension 273mg, 410mg, 546mg, 819mg

RisperdalCONSTA® risperidone Long-Acting Injection 12.5mg, 25mg, 37.5mg, 50mg

Insurance

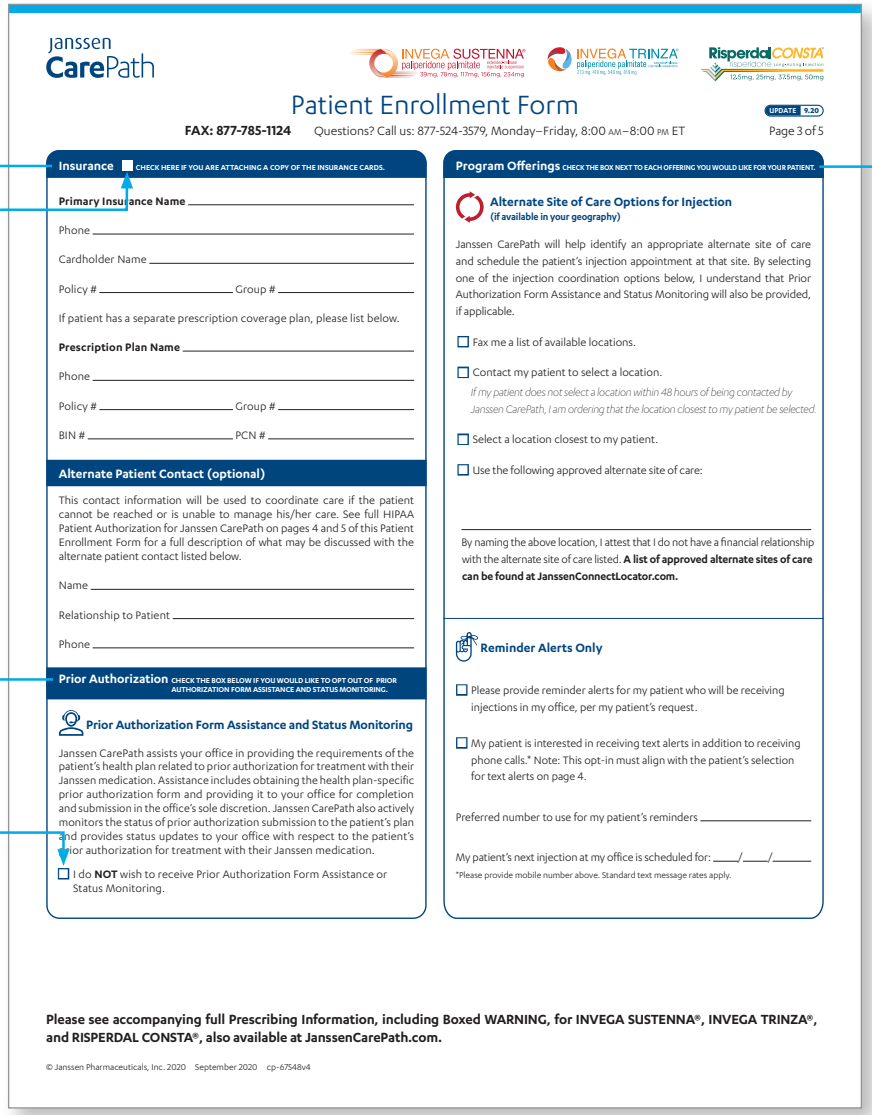
- Check this box if attaching a copy of the patient's insurance cards

OR

- Fill in all required insurance information
- Include separate prescription drug insurance (if applicable)

Prior Authorization

- Prior Authorization Form Assistance and Status Monitoring support is automatically provided with benefits investigation
- Only check this box if you want to OPT OUT of Prior Authorization Form Assistance and Status Monitoring



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FAX: 877-785-1124 Questions? Call us: 877-524-3579, Monday–Friday, 8:00 AM–8:00 PM ET Page 3 of 5

Insurance ☐ CHECK HERE IF YOU ARE ATTACHING A COPY OF THE INSURANCE CARDS.

Primary Insurance Name _____

Phone _____

Cardholder Name _____

Policy # _____ Group # _____

If patient has a separate prescription coverage plan, please list below.

Prescription Plan Name _____

Phone _____

Policy # _____ Group # _____

BIN # _____ PCN # _____

Alternate Patient Contact (optional)

This contact information will be used to coordinate care if the patient cannot be reached or is unable to manage his/her care. See full HIPAA Patient Authorization for Janssen CarePath on pages 4 and 5 of this Patient Enrollment Form for a full description of what may be discussed with the alternate patient contact listed below.

Name _____

Relationship to Patient _____

Phone _____

Prior Authorization CHECK THE BOX BELOW IF YOU WOULD LIKE TO OPT OUT OF PRIOR AUTHORIZATION FORM ASSISTANCE AND STATUS MONITORING.

Prior Authorization Form Assistance and Status Monitoring

Janssen CarePath assists your office in providing the requirements of the patient's health plan related to prior authorization for treatment with their Janssen medication. Assistance includes obtaining the health plan-specific prior authorization form and providing it to your office for completion and submission in the office's sole discretion. Janssen CarePath also actively monitors the status of prior authorization submission to the patient's plan and provides status updates to your office with respect to the patient's prior authorization for treatment with their Janssen medication.

☐ I do **NOT** wish to receive Prior Authorization Form Assistance or Status Monitoring.

Program Offerings CHECK THE BOX NEXT TO EACH OFFERING YOU WOULD LIKE FOR YOUR PATIENT.

Alternate Site of Care Options for Injection (if available in your geography)

Janssen CarePath will help identify an appropriate alternate site of care and schedule the patient's injection appointment at that site. By selecting one of the injection coordination options below, I understand that Prior Authorization Form Assistance and Status Monitoring will also be provided, if applicable.

☐ Fax me a list of available locations.

☐ Contact my patient to select a location.

If my patient does not select a location within 48 hours of being contacted by Janssen CarePath, I am ordering that the location closest to my patient be selected.

☐ Select a location closest to my patient.

☐ Use the following approved alternate site of care:

_____

By naming the above location, I attest that I do not have a financial relationship with the alternate site of care listed. **A list of approved alternate sites of care can be found at JanssenConnectLocator.com.**

Reminder Alerts Only

☐ Please provide reminder alerts for my patient who will be receiving injections in my office, per my patient's request.

☐ My patient is interested in receiving text alerts in addition to receiving phone calls.* Note: This opt-in must align with the patient's selection for text alerts on page 4.

Preferred number to use for my patient's reminders _____

My patient's next injection at my office is scheduled for: ____/____/_____

*Please provide mobile number above. Standard text message rates apply.

Please see accompanying full Prescribing Information, including Boxed WARNING, for INVEGA SUSTENNA®, INVEGA TRINZA®, and RISPERDAL CONSTA®, also available at JanssenCarePath.com.

Program Offerings

- Check the appropriate box(es) for the offering(s) you would like to request for your patient:
  - Alternate Site of Care Options for Injection (if available in the patient's geography)
  - Reminder Alerts Only
- Fill in all requested information for each offering selected

Janssen CarePath

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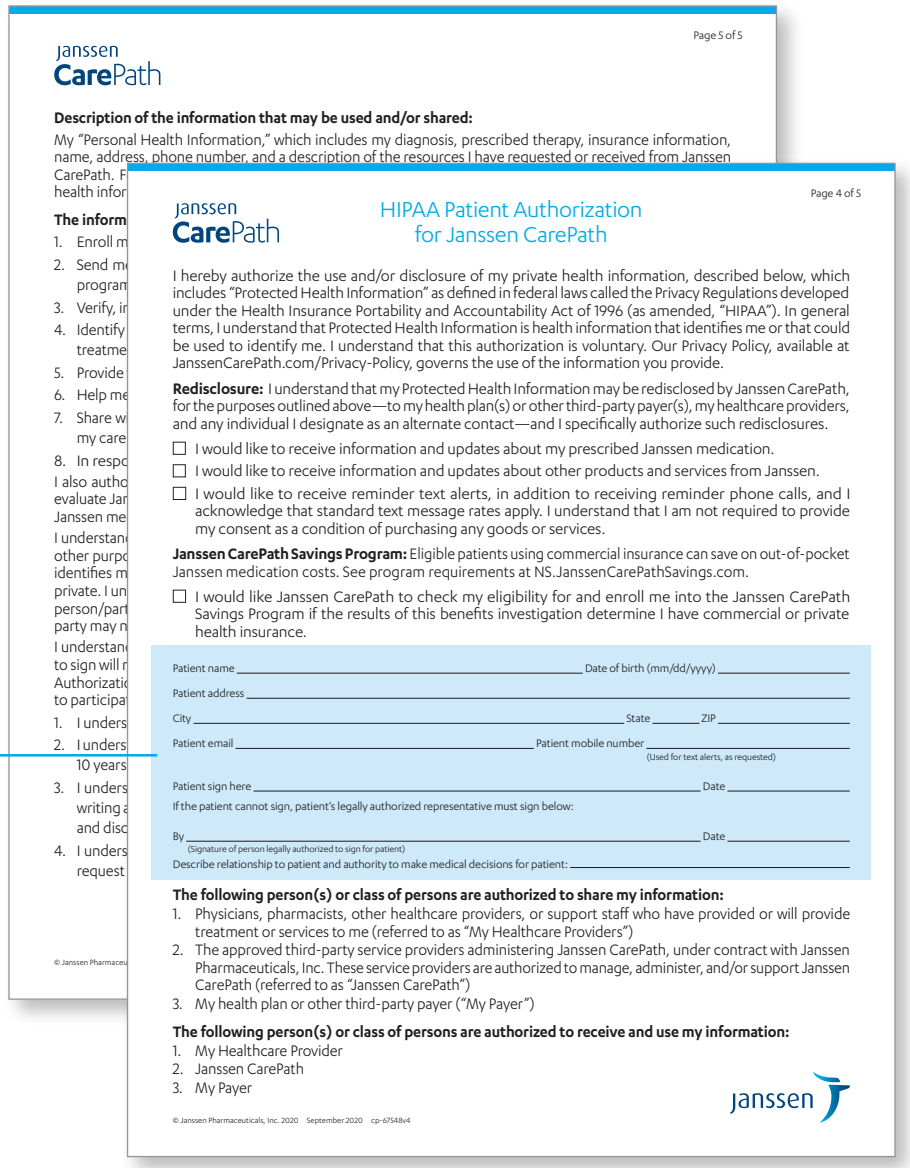
RisperdalCONSTA® risperidone Long-Acting Injection 12.5mg, 25mg, 37.5mg, 50mg

HIPAA Patient Authorization Form for Janssen CarePath

- Have your patient read, sign, and date the HIPAA Patient Authorization Form
- Give your patient a copy of the signed HIPAA Patient Authorization Form and keep the original for your records

DON'T FORGET! Your patient has the option to check the box(es) to **OPT IN** to receive information and updates about their prescribed Janssen medication, information about other Janssen products and services, and reminder text alerts.



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Janssen CarePath

Description of the information that may be used and/or shared:

My "Personal Health Information," which includes my diagnosis, prescribed therapy, insurance information, name, address, phone number, and a description of the resources I have requested or received from Janssen CarePath. F
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Janssen CarePath

HIPAA Patient Authorization for Janssen CarePath

I hereby authorize the use and/or disclosure of my private health information, described below, which includes "Protected Health Information" as defined in federal laws called the Privacy Regulations developed under the Health Insurance Portability and Accountability Act of 1996 (as amended, "HIPAA"). In general terms, I understand that Protected Health Information is health information that identifies me or that could be used to identify me. I understand that this authorization is voluntary. Our Privacy Policy, available at JanssenCarePath.com/Privacy-Policy, governs the use of the information you provide.

Redisclosure: I understand that my Protected Health Information may be redisclosed by Janssen CarePath, for the purposes outlined above—to my health plan(s) or other third-party payer(s), my healthcare providers, and any individual I designate as an alternate contact—and I specifically authorize such redisclosures.

☐ I would like to receive information and updates about my prescribed Janssen medication.
☐ I would like to receive information and updates about other products and services from Janssen.
☐ I would like to receive reminder text alerts, in addition to receiving reminder phone calls, and I acknowledge that standard text message rates apply. I understand that I am not required to provide my consent as a condition of purchasing any goods or services.

Janssen CarePath Savings Program: Eligible patients using commercial insurance can save on out-of-pocket Janssen medication costs. See program requirements at NS.JanssenCarePathSavings.com.

☐ I would like Janssen CarePath to check my eligibility for and enroll me into the Janssen CarePath Savings Program if the results of this benefits investigation determine I have commercial or private health insurance.

Patient name _____ Date of birth (mm/dd/yyyy) _____
Patient address _____
City _____ State _____ ZIP _____
Patient email _____ Patient mobile number _____ (Used for text alerts, as requested)
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: _____

The following person(s) or class of persons are authorized to share my information:

1. Physicians, pharmacists, other healthcare providers, or support staff who have provided or will provide treatment or services to me (referred to as "My Healthcare Providers")
2. The approved third-party service providers administering Janssen CarePath, under contract with Janssen Pharmaceuticals, Inc. These service providers are authorized to manage, administer, and/or support Janssen CarePath (referred to as "Janssen CarePath")
3. My health plan or other third-party payer ("My Payer")

The following person(s) or class of persons are authorized to receive and use my information:

1. My Healthcare Provider
2. Janssen CarePath
3. My Payer

Janssen

Fax pages 1, 3, 4, and 5 of the completed and signed PEF to Janssen CarePath at **877-785-1124**.

Important: To ensure the patient's Verification of Benefits is provided in a timely manner, please complete ALL required fields highlighted in **BLUE.**

Please see full Prescribing Information, including Boxed WARNING, for INVEGA SUSTENNA®, INVEGA TRINZA®, and RISPERDAL CONSTA®.

Janssen CarePath

Understanding Your Patients' Benefits

Following receipt of the PEF for INVEGA SUSTENNA®, INVEGA TRINZA®, or RISPERDAL CONSTA®, Janssen CarePath will verify insurance benefits and provide your office with a Verification of Benefits and Alternate Site of Care (ASOC) Options for Injection Form.

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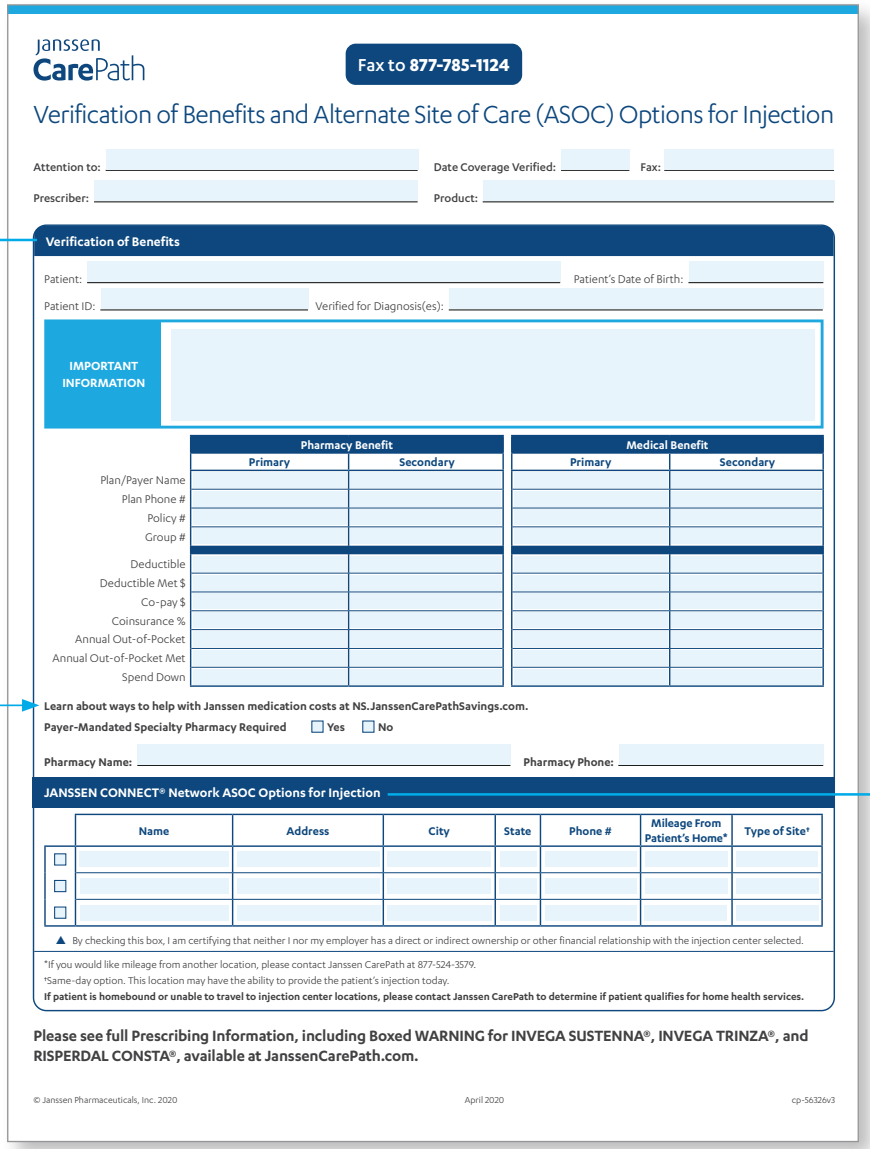
Verification of Benefits

- Patient name, date of birth, and ID
- Pharmacy and medical benefits information is provided for primary and secondary insurance
- Coverage details include:
  - Plan/payer name
  - Plan phone, policy, and group numbers
  - Deductible and amount met
  - Co-pay/coinsurance
  - Annual out-of-pocket maximum and amount met
  - Spend down
- Payer-Mandated Specialty Pharmacy:
  - Check box indicates whether payer-mandated specialty pharmacy is required
  - Pharmacy name and phone

For assistance with medication costs, patients may visit NS.JanssenCarePathSavings.com



Janssen CarePath

Fax to 877-785-1124

Verification of Benefits and Alternate Site of Care (ASOC) Options for Injection

Attention to: _____ Date Coverage Verified: _____ Fax: _____

Prescriber: _____ Product: _____

Verification of Benefits

Patient: _____ Patient's Date of Birth: _____

Patient ID: _____ Verified for Diagnosis(es): _____

IMPORTANT INFORMATION

	Pharmacy Benefit		Medical Benefit	
	Primary	Secondary	Primary	Secondary
Plan/Payer Name				
Plan Phone #				
Policy #				
Group #				
Deductible				
Deductible Met $				
Co-pay $				
Coinsurance %				
Annual Out-of-Pocket				
Annual Out-of-Pocket Met				
Spend Down				

Learn about ways to help with Janssen medication costs at NS.JanssenCarePathSavings.com.

Payer-Mandated Specialty Pharmacy Required ☐ Yes ☐ No

Pharmacy Name: _____ **Pharmacy Phone:** _____

JANSSEN CONNECT® Network ASOC Options for Injection

	Name	Address	City	State	Phone #	Mileage From Patient's Home*	Type of Site†
☐							
☐							
☐							

▲ By checking this box, I am certifying that neither I nor my employer has a direct or indirect ownership or other financial relationship with the injection center selected.

*If you would like mileage from another location, please contact Janssen CarePath at 877-524-3579.

†Same-day option. This location may have the ability to provide the patient's injection today.

If patient is homebound or unable to travel to injection center locations, please contact Janssen CarePath to determine if patient qualifies for home health services.

Please see full Prescribing Information, including Boxed WARNING for INVEGA SUSTENNA®, INVEGA TRINZA®, and RISPERDAL CONSTA®, available at JanssenCarePath.com.

April 2020

cp-56326v3

ASOC Options for Injection

- Name and contact information for alternate site(s) of care
- Mileage from patient's home and type of site
- If multiple locations are listed, check the appropriate box for the preferred location and fax or call Janssen CarePath to schedule the injection*

*Not available for all locations.

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Patient insurance benefits investigation is provided by third-party service providers for Janssen CarePath, under contract with Janssen Pharmaceuticals, Inc. (Janssen). Janssen CarePath is not available to patients participating in the Patient Assistance Program offered by Johnson & Johnson Patient Assistance Foundation. The availability of information and assistance may vary based on the Janssen medication, geography and other program differences. Janssen CarePath assists healthcare providers (HCPs) in the determination of whether treatment could be covered by the applicable third-party payer based on coverage guidelines provided by the payer, and patient information provided by the HCP under appropriate authorization following the provider's exclusive determination of medical necessity. This information and assistance are made available as a convenience to patients, and there is no requirement that patients or HCPs use any Janssen product in exchange for this information or assistance. Janssen assumes no responsibility for and does not guarantee the quality, scope, or availability of the information and assistance provided. The third-party service providers, not Janssen, are responsible for the information and assistance provided under this program. Each HCP and patient is responsible for verifying or confirming any information provided. All claims and other submissions to payers should be in compliance with all applicable requirements.

Third-party reimbursement is affected by many factors. This document and the information and assistance provided by Janssen CarePath are presented for informational purposes only. They do not constitute reimbursement or legal advice. Janssen CarePath does not promise or guarantee coverage, levels of reimbursement, or payment.

Similarly, all CPT®* and HCPCS codes are supplied for informational purposes only and represent no statement, promise, or guarantee, expressed or implied, by Janssen or its third-party service providers that these codes will be appropriate or that reimbursement will be made. The fact that a drug, device, procedure, or service is assigned an HCPCS code and a payment rate does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the Medicare program.

Laws, regulations, and policies concerning reimbursement are complex and are updated frequently. Accordingly, the information may not be current or comprehensive. Janssen and its third-party service providers strongly recommend you consult your payer for its most current coverage, reimbursement, and coding policies. Janssen and its third-party service providers make no representations or warranties, expressed or implied, as to the accuracy of the information provided. In no event shall the third-party service providers or Janssen, or their employees or agents, be liable for any damages resulting from or relating to any information provided by, or accessed to or through, Janssen CarePath. All HCPs and other users of this information agree that they accept responsibility for the use of this program.

* CPT® – Current Procedural Terminology. CPT® is a registered trademark of the American Medical Association, 2019.

Need help?

Visit **JanssenCarePath.com**

Call **877-524-3579**

Monday–Friday, 8:00 AM–8:00 PM ET

Please see full Prescribing Information, including Boxed WARNING, for INVEGA SUSTENNA®, INVEGA TRINZA®, and RISPERDAL CONSTA®.

Janssen Pharmaceutical Companies of Johnson & Johnson

 October 2020 cp-84487v2