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 INVEGA HAFYERA™.

Janssen CarePath

Completing the Patient Enrollment Form (PEF)

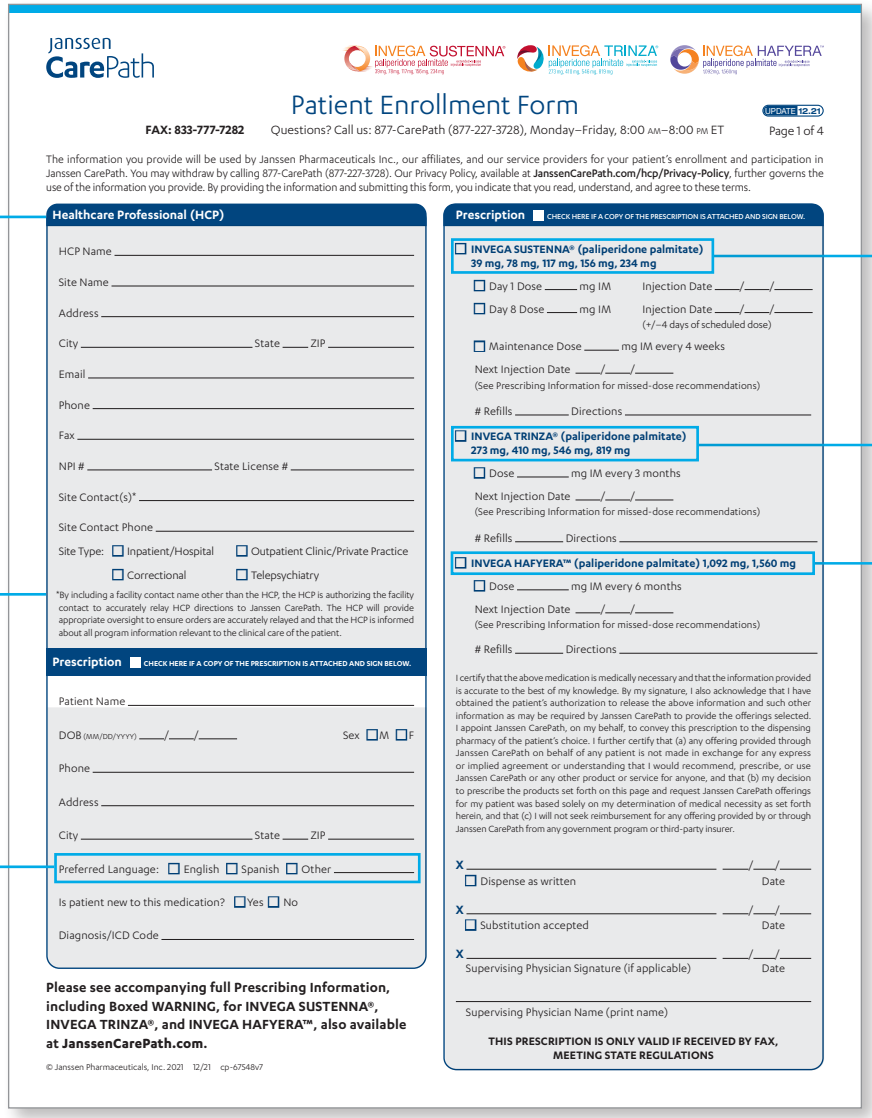
Once a treatment decision has been made to prescribe INVEGA SUSTENNA® (paliperidone palmitate), INVEGA TRINZA® (paliperidone palmitate), or INVEGA HAFYERA™ (paliperidone palmitate), use the PEF to provide information about your patient and your office to request Janssen CarePath to support therapy with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

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 | INVEGA TRINZA® paliperidone palmitate | INVEGA HAFYERA® paliperidone palmitate

Patient Enrollment Form

UPDATE 12.21

FAX: 833-777-7282 Questions? Call us: 877-CarePath (877-227-3728), Monday–Friday, 8:00 AM–8:00 PM ET Page 1 of 4

The information you provide will be used by Janssen Pharmaceuticals Inc., our affiliates, and our service providers for your patient's enrollment and participation in Janssen CarePath. You may withdraw by calling 877-CarePath (877-227-3728). Our Privacy Policy, available at **JanssenCarePath.com/hcp/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.

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 see accompanying full Prescribing Information, including Boxed WARNING, for INVEGA SUSTENNA®, INVEGA TRINZA®, and INVEGA HAFYERA™, 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 _____

☐ **INVEGA HAFYERA™ (paliperidone palmitate) 1,092 mg, 1,560 mg**

☐ Dose _____ mg IM every 6 months

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

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 INVEGA HAFYERA™
- 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 **GRAY.**

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

Janssen CarePath

Insurance

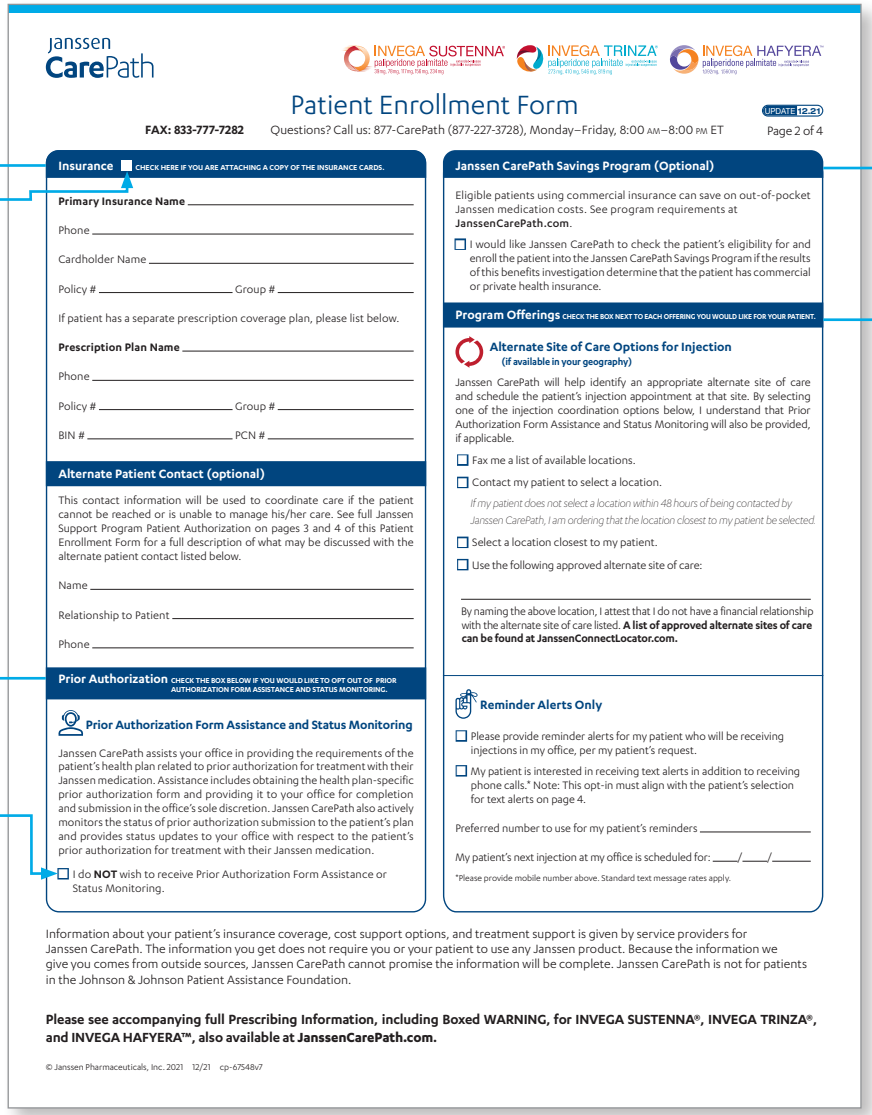
- Check this box if attaching a copy of the patient's insurance cards

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



Janssen CarePath

INVEGA SUSTENNA® paliperidone palmitate | INVEGA TRINZA® paliperidone palmitate | INVEGA HAFYERA™ paliperidone palmitate

Patient Enrollment Form

UPDATE 12.21

FAX: 833-777-7282 Questions? Call us: 877-CarePath (877-227-3728), Monday–Friday, 8:00 AM–8:00 PM ET Page 2 of 4

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 Janssen Support Program Patient Authorization on pages 3 and 4 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.

Janssen CarePath Savings Program (Optional)

Eligible patients using commercial insurance can save on out-of-pocket Janssen medication costs. See program requirements at **JanssenCarePath.com**.

☐ I would like Janssen CarePath to check the patient's eligibility for and enroll the patient into the Janssen CarePath Savings Program if the results of this benefits investigation determine that the patient has commercial or private health insurance.

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.

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.

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

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Janssen CarePath Savings Program

- Check the box to request that Janssen CarePath check your patient's eligibility and enroll them into the Janssen CarePath Savings Program if the results of their benefits investigation determine they have commercial or private health insurance

Program Offerings

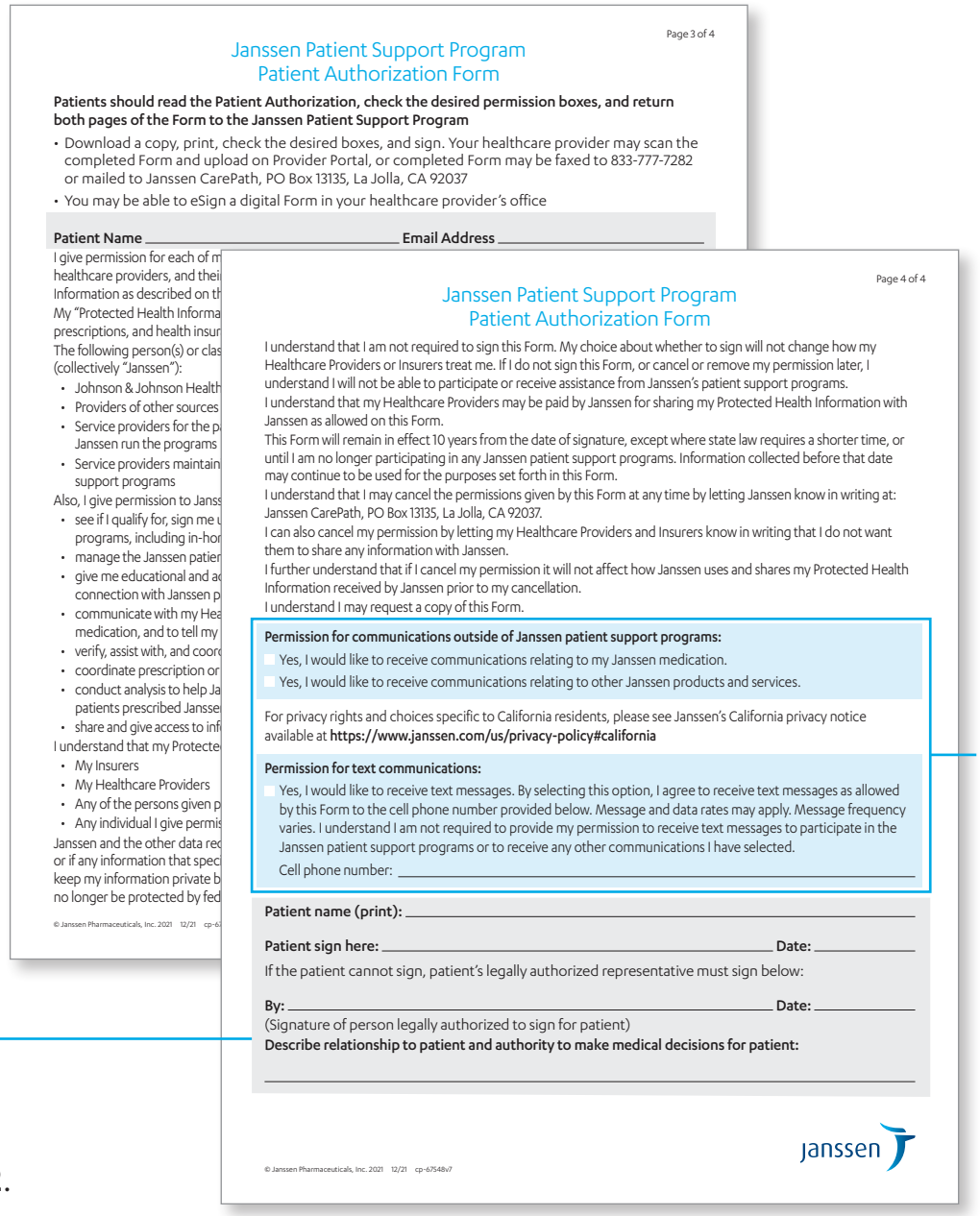
- Check the appropriate box(es) for the offering(s) you would like to request for your patient:
  - Alternate Site of Care Options for Injection (if available in the patient's geography)
  - Reminder Alerts Only
- Fill in all requested information for each offering selected

Please see full Prescribing Information, including Boxed WARNING, for **INVEGA SUSTENNA® (paliperidone palmitate)**, **INVEGA TRINZA® (paliperidone palmitate)**, and **INVEGA HAFYERA™ (paliperidone palmitate)**.

Janssen CarePath

Janssen Patient Support Program Patient Authorization Form

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



Page 3 of 4

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 833-777-7282 or mailed to Janssen CarePath, PO Box 13135, La Jolla, CA 92037
- You may be able to eSign a digital Form in your healthcare provider's office

Patient Name _____ **Email Address** _____

I give permission for each of m
healthcare providers, and thei
Information as described on th
My "Protected Health Informa
prescriptions, and health insur
The following person(s) or clas
(collectively "Janssen"):

- Johnson & Johnson Health
- Providers of other sources
- Service providers for the p
  Janssen run the programs
- Service providers maintain
  support programs

Also, I give permission to Janss

- see if I qualify for, sign me u
  programs, including in-hor
- manage the Janssen patier
- give me educational and ac
  connection with Janssen p
- communicate with my Hea
  medication, and to tell my
- verify, assist with, and coor
- coordinate prescription or
- conduct analysis to help Ja
  patients prescribed Janssel
- share and give access to infi

I understand that my Protecte

- My Insurers
- My Healthcare Providers
- Any of the persons given p
- Any individual I give permis

Janssen and the other data rec
or if any information that spec
keep my information private b
no longer be protected by fed

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Page 4 of 4

Janssen Patient Support Program
Patient Authorization Form

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, PO Box 13135, La Jolla, CA 92037.
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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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 text communications.

Fax pages 1-4 of the completed and signed PEF to Janssen CarePath at **833-777-7282**.

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

Janssen CarePath

Understanding Your Patients' Benefits

Following receipt of the PEF for INVEGA SUSTENNA® (paliperidone palmitate), INVEGA TRINZA® (paliperidone palmitate), or INVEGA HAFYERA™ (paliperidone palmitate), Janssen CarePath will verify insurance benefits and provide your office with a Verification of Benefits (VOB).

Case Information

- Overview of the prescriber and patient clinical information
- Shows the Patient ID generated by Janssen CarePath, which serves as the single patient identifier across all Case IDs for a specific patient

Injection Center Information

- The Alternate Site of Care for Injection, selected by patient or prescriber, will be shown here. Contact information and additional Alternate Sites of Care will be shown in the "Additional Instructions" field in the Primary Pharmacy Insurance section

Primary Medical Insurance

- Outlines your patient's primary medical insurance
- Shows the outcome of the benefits investigation and indicates the patient's status as active or not active

Coverage Summary*

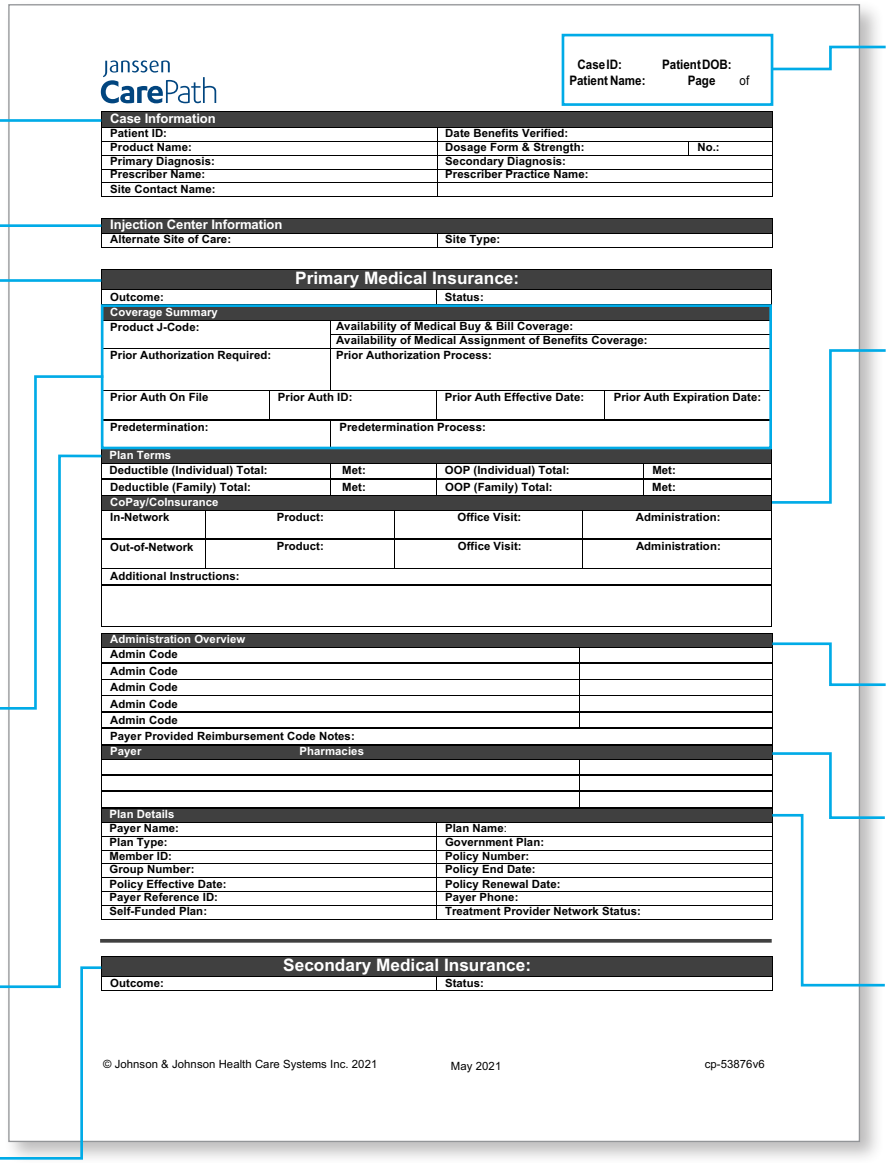
- The Coverage Summary table details prior authorization requirements, including whether a previous effective prior authorization is on file
- If applicable, also indicates whether predetermination is available, recommended, or required

Plan Terms*

- Outlines the annual Individual (and Family, if applicable), Deductible, and Out-of-Pocket (OOP) patient responsibility and the amount met to date

Secondary Medical Insurance

- If your patient has Secondary Medical Insurance, coverage details are outlined here. This section is similar to the Primary Medical Insurance section above



Janssen CarePath

Case ID: Patient DOB:
Patient Name: Page of

Case Information

Patient ID:	Date Benefits Verified:	
Product Name:	Dosage Form & Strength:	No.:
Primary Diagnosis:	Secondary Diagnosis:	
Prescriber Name:	Prescriber Practice Name:	
Site Contact Name:		

Injection Center Information

Alternate Site of Care:	Site Type:

Primary Medical Insurance:

Outcome:	Status:

Coverage Summary

Product J-Code:	Availability of Medical Buy & Bill Coverage: Availability of Medical Assignment of Benefits Coverage:		
Prior Authorization Required:	Prior Authorization Process:		
Prior Auth On File	Prior Auth ID:	Prior Auth Effective Date:	Prior Auth Expiration Date:
Predetermination:	Predetermination Process:		

Plan Terms

Deductible (Individual) Total:	Met:	OOP (Individual) Total:	Met:
Deductible (Family) Total:	Met:	OOP (Family) Total:	Met:

CoPay/CoInsurance

In-Network	Product:	Office Visit:	Administration:
Out-of-Network	Product:	Office Visit:	Administration:

Additional Instructions:

Administration Overview

Admin Code	
Admin Code	
Admin Code	
Admin Code	
Admin Code	

Payer Provided Reimbursement Code Notes:

Payer	Pharmacies

Plan Details

Payer Name:	Plan Name:
Plan Type:	Government Plan:
Member ID:	Policy Number:
Group Number:	Policy End Date:
Policy Effective Date:	Policy Renewal Date:
Payer Reference ID:	Payer Phone:
Self-Funded Plan:	Treatment Provider Network Status:

Secondary Medical Insurance:

Outcome:	Status:

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*The Verification of Benefits contains information that Janssen CarePath is able to obtain from the payer. If any information is missing or removed, it is because Janssen CarePath was unable to collect that specific detail, or because the field was not applicable.

Header

- Case ID, Patient Name, and Patient DOB appear on the top of every page of the VOB
- The Case ID is generated by Janssen CarePath and is specific to the benefits investigation outlined on the VOB
  - A new Case ID is created for each new benefits investigation

CoPay/CoInsurance*

- Lists information on your patient's CoPay/CoInsurance responsibility
- The Additional Instructions field highlights the patient's coverage and contains any pertinent details that may be needed
  - The patient's enrollment status in the Janssen CarePath Savings Program will be shown here

Administration Overview

- Provides the administration code(s) appropriate to the benefits shown

Payer (Preferred/Mandated) Pharmacies

- Lists payer preferred or mandated pharmacies and their telephone numbers, if available

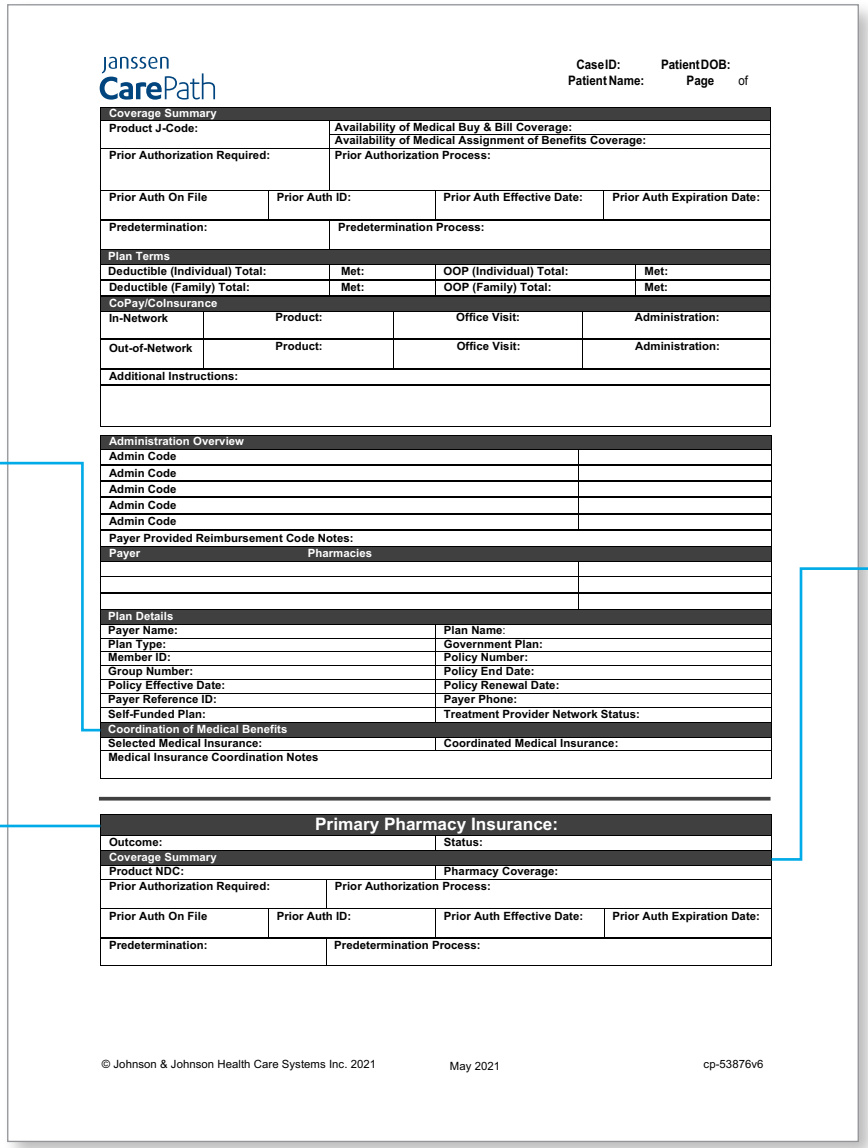
Plan Details

- Shows your patient's plan details, including the payer-generated Payer Reference ID from the benefits investigation call, if provided
- You may be asked for this ID when speaking directly with the payer regarding the patient's insurance coverage

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

Understanding Your Patients' Benefits (cont'd)

Following receipt of the PEF for INVEGA SUSTENNA® (paliperidone palmitate), INVEGA TRINZA® (paliperidone palmitate), or INVEGA HAFYERA™ (paliperidone palmitate), Janssen CarePath will verify insurance benefits and provide your office with a Verification of Benefits (VOB).



Janssen CarePath

Case ID: Patient DOB:
Patient Name: Page of

Coverage Summary

Product J-Code:	Availability of Medical Buy & Bill Coverage:
	Availability of Medical Assignment of Benefits Coverage:
Prior Authorization Required:	Prior Authorization Process:

Prior Auth On File	Prior Auth ID:	Prior Auth Effective Date:	Prior Auth Expiration Date:

Predetermination:	Predetermination Process:

Plan Terms

Deductible (Individual) Total:	Met:	OOP (Individual) Total:	Met:
Deductible (Family) Total:	Met:	OOP (Family) Total:	Met:

CoPay/CoInsurance

In-Network	Product:	Office Visit:	Administration:
Out-of-Network	Product:	Office Visit:	Administration:

Additional Instructions:

Administration Overview

Admin Code	
Admin Code	
Admin Code	
Admin Code	
Admin Code	

Payer Provided Reimbursement Code Notes:

Payer	Pharmacies

Plan Details

Payer Name:	Plan Name:
Plan Type:	Government Plan:
Member ID:	Policy Number:
Group Number:	Policy End Date:
Policy Effective Date:	Policy Renewal Date:
Payer Reference ID:	Payer Phone:
Self-Funded Plan:	Treatment Provider Network Status:

Coordination of Medical Benefits

Selected Medical Insurance:	Coordinated Medical Insurance:
Medical Insurance Coordination Notes	

Primary Pharmacy Insurance:

Outcome:	Status:

Coverage Summary

Product NDC:	Pharmacy Coverage:
Prior Authorization Required:	Prior Authorization Process:

Prior Auth On File	Prior Auth ID:	Prior Auth Effective Date:	Prior Auth Expiration Date:

Predetermination:	Predetermination Process:

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Coordination of Medical Benefits

- Outlines how medical benefits will be coordinated between your patient's two insurance options

Primary Pharmacy Insurance

- Outlines your patient's primary pharmacy insurance
- Shows the outcome of the benefits investigation and indicates the patient's status as active or not active

Coverage Summary*

- The Coverage Summary table shows your patient's pharmacy coverage and details prior authorization requirements, including whether a previous effective prior authorization is on file
- If applicable, also indicates whether predetermination is available, recommended, or required

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Janssen CarePath

Understanding Your Patients' Benefits (cont'd)

Following receipt of the PEF for INVEGA SUSTENNA® (paliperidone palmitate), INVEGA TRINZA® (paliperidone palmitate), or INVEGA HAFYERA™ (paliperidone palmitate), Janssen CarePath will verify insurance benefits and provide your office with a Verification of Benefits (VOB).

Plan Terms*

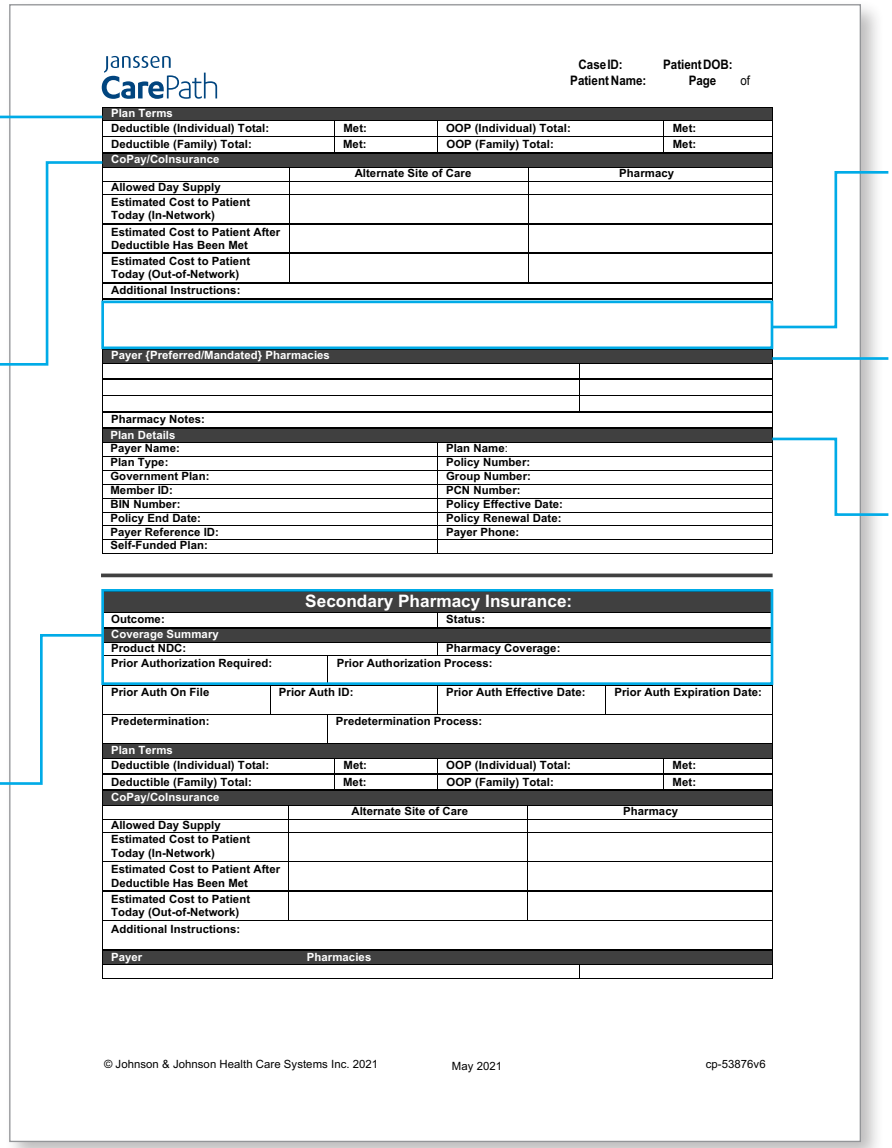
- Outlines the annual Individual (and Family, if applicable) Deductible and Out-of-Pocket (OOP) patient responsibility and the amount met to date

CoPay/CoInsurance*

- Lists the patient's estimated total cost "today," as well as the estimated cost to the patient after the deductible has been met
- The Additional Instructions field highlights the patient's coverage and contains any pertinent details that may be needed
  - Alternate Sites of Care for Injection, selected by patient or prescriber, will also be shown here

Secondary Pharmacy Insurance

- If your patient has Secondary Pharmacy Insurance, coverage details are outlined here. This section is similar to the Primary Pharmacy Insurance section above



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Case ID: Patient DOB:
Patient Name: Page of

Plan Terms			
Deductible (Individual) Total:	Met:	OOP (Individual) Total:	Met:
Deductible (Family) Total:	Met:	OOP (Family) Total:	Met:

CoPay/CoInsurance	Alternate Site of Care	Pharmacy
Allowed Day Supply		
Estimated Cost to Patient Today (In-Network)		
Estimated Cost to Patient After Deductible Has Been Met		
Estimated Cost to Patient Today (Out-of-Network)		
Additional Instructions:		

Payer {Preferred/Mandated} Pharmacies	
Pharmacy Notes:	

Plan Details	
Payer Name:	Plan Name:
Plan Type:	Policy Number:
Government Plan:	Group Number:
Member ID:	PCN Number:
BIN Number:	Policy Effective Date:
Policy End Date:	Policy Renewal Date:
Payer Reference ID:	Payer Phone:
Self-Funded Plan:	

Secondary Pharmacy Insurance:			
Outcome:		Status:	
Coverage Summary			
Product NDC:		Pharmacy Coverage:	
Prior Authorization Required:	Prior Authorization Process:		
Prior Auth On File	Prior Auth ID:	Prior Auth Effective Date:	Prior Auth Expiration Date:
Predetermination:	Predetermination Process:		

Plan Terms			
Deductible (Individual) Total:	Met:	OOP (Individual) Total:	Met:
Deductible (Family) Total:	Met:	OOP (Family) Total:	Met:

CoPay/CoInsurance	Alternate Site of Care	Pharmacy
Allowed Day Supply		
Estimated Cost to Patient Today (In-Network)		
Estimated Cost to Patient After Deductible Has Been Met		
Estimated Cost to Patient Today (Out-of-Network)		
Additional Instructions:		

Payer	Pharmacies

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Savings Program Statement

- The patient's enrollment status in the Janssen CarePath Savings Program will be shown here

Payer (Preferred/Mandated) Pharmacies

- Lists payer preferred or mandated pharmacies and their telephone numbers, if available

Plan Details

- Shows your patient's plan details, including the payer-generated Payer Reference ID from the benefits investigation call, if provided
- You may be asked for this ID when speaking directly with the payer regarding the patient's insurance coverage

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

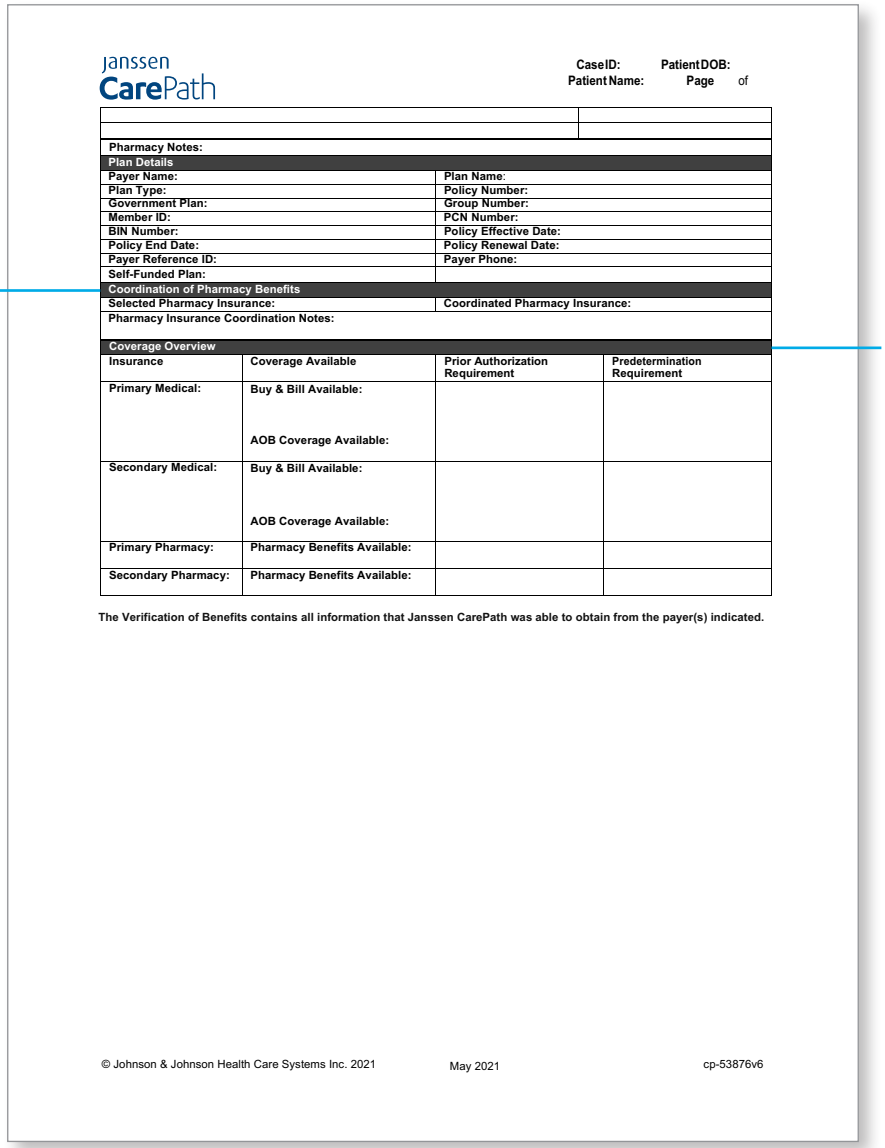
janssen CarePath

Understanding Your Patients' Benefits (cont'd)

Following receipt of the PEF for INVEGA SUSTENNA® (paliperidone palmitate), INVEGA TRINZA® (paliperidone palmitate), or INVEGA HAFYERA™ (paliperidone palmitate), Janssen CarePath will verify insurance benefits and provide your office with a Verification of Benefits (VOB).

Coordination of Pharmacy Benefits

- Outlines how pharmacy benefits will be coordinated between your patient's two insurance options



janssen CarePath

Case ID: Patient DOB:
Patient Name: Page of

Pharmacy Notes:

Plan Details

Payer Name:	**Plan Name:**
Plan Type:	**Policy Number:**
Government Plan:	**Group Number:**
Member ID:	**PCN Number:**
BIN Number:	**Policy Effective Date:**
Policy End Date:	**Policy Renewal Date:**
Payer Reference ID:	**Payer Phone:**
Self-Funded Plan:	

Coordination of Pharmacy Benefits

Selected Pharmacy Insurance:	**Coordinated Pharmacy Insurance:**

Pharmacy Insurance Coordination Notes:

Coverage Overview

Insurance	Coverage Available	Prior Authorization Requirement	Predetermination Requirement
Primary Medical:	**Buy & Bill Available:** **AOB Coverage Available:**		
Secondary Medical:	**Buy & Bill Available:** **AOB Coverage Available:**		
Primary Pharmacy:	**Pharmacy Benefits Available:**		
Secondary Pharmacy:	**Pharmacy Benefits Available:**		

The Verification of Benefits contains all information that Janssen CarePath was able to obtain from the payer(s) indicated.

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Coverage Overview

- Provides highlights of your patient's insurance coverage

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

Janssen CarePath

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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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.

This information is not a promise of coverage or payment. It is not intended to give reimbursement advice or increase reimbursement by any payer. The fact that a treatment is assigned a code and payment rate does not promise that it will be covered. Codes are used to describe products, procedures, or services on insurance claims. Payers use these codes with other information to figure out if treatment will be covered, and how much will be paid if covered. Legal requirements and plan information can be updated frequently. Contact the plan for more information about current coverage, reimbursement policies, restrictions, or requirements that may apply.

Benefits verified on date listed at the top of the form and may change.

Janssen CarePath

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

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