Janssen CarePath

INVEGA SUSTENNA® paliperidone palmitate extended-release injectable suspension 39mg, 78mg, 117mg, 156mg, 234mg

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

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

Patient Enrollment Form Cover Sheet

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

Date _____ **Pages** _____

Subject: Janssen CarePath Patient Enrollment

From _____

Fax # _____

Help empower your patient to start and stay on your prescribed treatment plan.

To enroll your patient:

1. Complete the **required** pages of the Patient Enrollment Form as noted below:

- ☐ **Page 1 of 5—REQUIRED:** Healthcare Professional Information and Prescription
  Please ensure there is a Healthcare Professional signature in the Prescription section.
- ☐ **Page 3 of 5—REQUIRED:** Patient Insurance Information and Program Offerings
- ☐ **Pages 4 and 5 of 5—REQUIRED:** HIPAA Authorization for Janssen CarePath
  Please ensure there is a Patient Signature or "person legally authorized to sign" signature on the Patient Authorization.

2. Fax pages 1, 3, 4, and 5 of 5 to Janssen CarePath: 877-785-1124

Upon receipt of your completed Patient Enrollment Form:

- A Fax Confirmation will be sent to your office
- We will begin working on your selected Program Offerings
- We will contact you with next steps

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®.

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Patient Enrollment Form

UPDATE 9.20

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

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

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Patient insurance benefits investigation and other Janssen CarePath program offerings are 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.

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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.

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

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** 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

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. For prescribed therapies, I understand that the information disclosed about me may include mental health information and/or records.

The information will be used and/or shared for the following purpose(s) as applicable:

1. Enroll me in, determine my eligibility for, and contact me about Janssen medication support programs
2. Send me requested educational materials, information, and resources related to the Janssen CarePath program or my Janssen medication
3. Verify, investigate, assist with, and coordinate my coverage for my Janssen medication with My Payer
4. Identify treatment location and/or provide information and assistance to help my transition to my next treatment location
5. Provide welcome and reminder alerts
6. Help me determine additional alternate site of care options for injection
7. Share with my Healthcare Provider(s) information generated by Janssen CarePath that may be useful for my care
8. In response to a court order, subpoena, or otherwise required by law

I also authorize Janssen CarePath to de-identify and use my health information to improve, develop, and evaluate Janssen CarePath, its offerings and materials, and to evaluate patient access to and adherence to my Janssen medication.

I understand that my Protected Health Information will not be used or disclosed by Janssen CarePath for any other purpose without my prior authorization unless permitted by law or unless information that specifically identifies me is removed. I understand that Janssen CarePath will make every effort to keep my information private. I understand that if my information is accidentally shared, federal privacy laws do not require that the person/party receiving it will not disclose the information further and that such information provided to a third party may no longer be protected by federal privacy laws.

I understand that I am not required to sign this HIPAA Patient Authorization Form. My choice about whether to sign will not change the way my Healthcare Providers or Payer treat me. If I refuse to sign the HIPAA Patient Authorization Form, or cancel or revoke my authorization later, I understand that this means I will not be able to participate or receive assistance from Janssen CarePath.

1. I understand that I am entitled to a signed copy of this authorization.
2. I understand that this authorization shall expire either when I stop receiving Janssen CarePath resources or 10 years from the date of this authorization, whichever occurs first.
3. I understand that I may cancel or revoke this authorization at any time by notifying Janssen CarePath in writing at the following toll-free fax number: 877-785-1124. I understand this will not affect information used and disclosed prior to receipt of my cancellation or revocation.
4. I understand that I have the right to review my health information that has been disclosed upon written request to Janssen CarePath at the following toll-free fax number: 877-785-1124.

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