Janssen CarePath

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

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

INVEGA HAFYERA™ paliperidone palmitate extended-release injectable suspension 1,092mg, 1,560mg

Patient Enrollment Form Cover Sheet

UPDATE 12.21

FAX: 833-777-7282 Questions? Call us: 877-CarePath (877-227-3728), 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 4—REQUIRED:** Healthcare Professional Information and Prescription
  Please ensure there is a Healthcare Professional signature in the Prescription section.
- ☐ **Page 2 of 4—REQUIRED:** Patient Insurance Information and Program Offerings
- ☐ **Pages 3 and 4 of 4—REQUIRED:** Janssen Patient Support Program Patient Authorization
  Please ensure there is a Patient Signature on the Patient Authorization or that a legally authorized representative has signed on behalf of the patient.

2. Fax pages 1, 2, 3, and 4 of 4 to Janssen CarePath: 833-777-7282

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

Fax **833-777-7282**

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

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

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Patient Enrollment Form

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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 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 _____

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

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

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

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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 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 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

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.

CLEAR PRINT

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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