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

ZYTIGA AFTER ERLEADA™ Voucher Program
Patient Enrollment Form

Phone: 877-CarePath (877-227-3728) Fax: 855-998-4422 JanssenCarePathPortal.com

ELIGIBILITY REQUIREMENTS (Required) If any of the answers below are marked "No," the patient is not eligible for this program.

1. Was the patient prescribed ERLEADA® (apalutamide) for non-metastatic castration-resistant prostate cancer (nmCRPC) or metastatic castration-sensitive prostate cancer (mCSPC)? ☐ Yes ☐ No
2. While taking ERLEADA®, has the patient's disease progressed to metastatic castration-resistant prostate cancer (mCRPC) on or after September 1, 2019? ☐ Yes ☐ No
3. Subsequent to progressing while taking ERLEADA®, do you confirm the patient has not been prescribed abiraterone acetate or enzalutamide for mCRPC? ☐ Yes ☐ No

PRESCRIBER INFORMATION (Required)

FIRST NAME ______ LAST NAME ______ PRACTICE NAME ______

ADDRESS ______ CITY ______ STATE ______ ZIP CODE ______

PHONE # ______ OFFICE–MAIN FAX # ______

STATE LICENSE # ______ UPIN/NPI # ______

PATIENT INFORMATION (Required)

FIRST NAME ______ MI ______ LAST NAME ______ LANGUAGE ☐ English ☐ Spanish

☐ Male ☐ Female DATE OF BIRTH (MM/DD/YYYY) ______ EMAIL ______

ADDRESS ______ CITY ______ STATE ______ ZIP ______

PRIMARY PHONE ______ SECONDARY PHONE (Optional) ______ BEST TIME TO CONTACT ______

CAREGIVER/CONTACT ______
(A caregiver/contact is someone who can be contacted in place of the patient)

PHONE ______ BEST TIME TO CONTACT ______

☐ I authorize Janssen CarePath to leave a message, including the name of the Janssen medication indicated on this form, if I am unavailable when they call.

Please sign the Patient Authorization on pages 3-4.

☐ If I cannot be reached, I authorize Janssen CarePath to contact my caregiver.

☐ I prefer and authorize Janssen CarePath to contact my caregiver in place of me.

INSURANCE INFORMATION (Required) Please provide information on insurance coverage for prescription drugs (pharmacy benefits). Insurance information will be used for a benefits investigation at the conclusion of the Voucher Program if the patient and prescriber elect to continue therapy.

☐ Please see attached front and back copy of insurance card.

PRESCRIPTION DRUG INSURANCE ______

CARD BIN # ______ PHONE ______

CARDHOLDER NAME (First, MI, Last) ______

RELATIONSHIP TO CARDHOLDER ______

POLICY # ______ GROUP # ______

PRESCRIPTION INFORMATION: To be completed by physician

Rx ZYTIGA® ☐ 250 mg Tablet QUANTITY 120 REFILLS # 3

DIRECTIONS: Take ______ mg PO QD on an empty stomach. NOTE: Patient must discontinue treatment with ERLEADA® prior to initiating treatment with ZYTIGA®.

ZYTIGA® is indicated in combination with prednisone. It is your responsibility to initiate a separate prescription for prednisone to be taken with ZYTIGA®. Prednisone will not be given to the patient as a part of this voucher program. NOTE: Janssen CarePath will not investigate benefits for prednisone. Please refer to the full Prescribing Information for complete information prior to initiating treatment.

PRESCRIBER SIGNATURE (NO STAMPS) REQUIRED. I certify that therapy with ZYTIGA® is medically necessary for this patient. I will be supervising the patient's treatment accordingly, and I have reviewed the current ZYTIGA® full Prescribing Information. I authorize Janssen CarePath to act on my behalf for the limited purposes of transmitting this prescription to Wegmans Specialty Pharmacy. I also indicate that the patient meets the program eligibility requirements as noted above and on the next page of this form. I wish to enroll the patient in the voucher program and understand that the patient will be contacted by Wegmans Specialty Pharmacy, on behalf of Janssen CarePath, to initiate therapy and schedule shipping of the medication.

PRESCRIBER SIGNATURE >> (Dispense as written) ______ DATE ______

SUPERVISING PHYSICIAN SIGNATURE >> (If applicable) ______ DATE ______

SUPERVISING PHYSICIAN NAME ______

Please read full Prescribing Information for ERLEADA® and ZYTIGA®.

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For assistance or additional information, call 877-CarePath (877-227-3728), Monday–Friday, 8:00 AM–8:00 PM ET

Program Eligibility Requirements for Janssen CarePath ZYTIGA AFTER ERLEADA™ Voucher Program

- The voucher program is open to patients who have commercial insurance, government coverage, or no insurance coverage; however, there is no guarantee of continuous accessibility after the program ends.
- Patients enrolled in a Medicare Part D plan are eligible for this free 4-month voucher program but may not submit a claim for the costs paid by this program to count toward true out-of-pocket (TrOOP) costs.
- Out-of-pocket costs paid by this program may not be submitted as a claim for payment to any third-party payer, pharmaceutical patient assistance foundation, or account such as a Flexible Spending Account (FSA), a Health Savings Account (HSA), or a Health Reimbursement Account (HRA).
- The program is limited to one 4-month supply per lifetime.
- Program terms will expire at the end of each calendar year. Program subject to change or discontinuation without notice, including in specific states.
- By participating in this program, you confirm that you have read, understood, and agree to the program requirements shown on this page, and you are giving permission for information related to your participation in this program to be shared with your healthcare provider(s).
- It is important that you understand that 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 necessary to permit Janssen Biotech, Inc., the maker of ZYTIGA® (abiraterone acetate), and companies that work with Janssen Biotech, Inc., including our affiliates and our service providers, to fulfill your request to enroll in the ZYTIGA AFTER ERLEADA™ Voucher Program. We may also use the information you give us to learn more about the people who use ZYTIGA® and to improve the information we provide to people who are being treated with ZYTIGA®. Janssen Biotech, Inc., will not share your information with anyone else except as required by law.
- This program offer may not be combined 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 otherwise restricted by law.

Janssen CarePath is in no way an extension of medical treatment provided by healthcare professionals to individual patients. You may discontinue your participation in the voucher program at any time by calling 866-889-5660.

How to enroll: Review the program requirements above. Complete this form, including the Patient Authorization on pages 3-4, and fax to 855-998-4422.

NOTE: Your signature on the last 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 see the full Prescribing Information for ERLEADA® (apalutamide) and ZYTIGA®.

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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 855-998-4422 or mailed to Janssen CarePath, 2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560**
  - **You may be able to eSign a digital Form in your healthcare provider's office or on the Janssen CarePath Patient Account at MyJanssenCarePath.com**

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 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, 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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