Tremfya withMe | Tremfya® (guselkumab)

Rebate Form

Submit this form if your pharmacy can't process your TREMFYA withMe Savings Program card.

Get started

STEP 1

You must be enrolled in the TREMFYA withMe Savings Program. You can enroll by texting "SAVINGS" to 56011 (message and data rates may apply*) or online at **MyJanssenCarePath.com/express**.

STEP 2

Use your card to complete the information on the next page. Sign the form.

STEP 3

Include a copy of the pharmacy receipt. A valid receipt will include your name, medication, date, and amount paid for your TREMFYA® medication. If your receipt includes a prescription number but does not include medication name, also include a copy of your prescription label from the medication carton.

STEP 4

Mail this signed form along with your pharmacy receipt and prescription label from the medication carton, if required, to the address on the next page, submit online at **MyJanssenCarePath.com**, or fax to 833-512-0495. Eligible patients will receive a rebate check.

*See **Terms** and **Privacy Policy**.

Please read the full Prescribing Information and Medication Guide for TREMFYA® and discuss any questions you have with your doctor.

Rebate Form TREMFYA® (guselkumab)

Read instructions on previous page, then complete the information below.

The information you provide will only be used by Janssen Biotech, Inc., the maker of TREMFYA®, our affiliates, and our service providers, to provide benefits to you related to the activation and use of your TREMFYA withMe Savings Program card. If you want to stop receiving this information or service, you may withdraw from the program by calling 833-withMe1 (833-948-4631). Our **Privacy Policy** governs the use of the information you provide.

☐ By providing consent, you agree to the collection and use of your Sensitive Personal Information (SPI). Examples of SPI may include, but are not limited to, health-related information. We use this information consistent with our Privacy Policy, including to personalize the information you receive, fulfill any requests you submit, and to research, develop, and improve our products and services. By checking the box, you indicate that you read, understand, and agree to such collection and use of your SPI.

***Required**

*Name

*Date of Birth (mm/dd/yyyy) *Gender ☐ M ☐ F

*Address

*City *State *ZIP Code

*E-mail *Phone

*11-digit Savings Program ID # found on the front of the card

This program is only for people age 18 or older using commercial or private health insurance who must pay an out-of-pocket cost for their Janssen medication. This includes plans from the Health Insurance Marketplace. This program is not for people who use any state or federal government-funded healthcare program. Examples of these programs are Medicare, Medicaid, TRICARE, Department of Defense, and Veterans Administration. You may not seek payment for the value received from this program from any health plan, patient assistance foundation, flexible spending account, or healthcare savings account.

You must meet the program requirements every time you use the Savings Program. Program terms will expire at the end of each calendar year. The program may change or end without notice, including in specific states. Program participants are subject to an annual maximum benefit. Program benefits are set at the discretion of Janssen and may change without notice.

To use this program, you must follow any health plan requirements, including telling your health plan how much co-payment support you get from this program, if required. By using the Savings Program, you confirm that you have read, understood, and agree to the program requirements, and you are giving permission for information related to your Savings Program transactions to be shared with your healthcare provider(s). These transactions include rebates and any funds placed on the card or balance remaining on the card. Offer good only in the United States and its territories. Void where prohibited, taxed, or limited by law. REBATE FORM CANNOT BE BOUGHT, TRANSFERRED, OR SOLD. REBATE FORM CANNOT BE COMBINED WITH ANY OTHER OFFER, DISCOUNT, PRESCRIPTION SAVINGS CARD, OR FREE TRIAL. Use of this program is subject to the program requirements, which can be found at **TREMFYAwithMeSavings.com**.

By signing, dating, and submitting this form, you confirm that **you:**

- **have enrolled in the TREMFYA withMe Savings Program and received your savings card. Note: TREMFYA withMe cannot process this rebate form if you have not yet received your Savings Program card; and**
- meet the program requirements of the Savings Program, which may also be found at **TREMFYAwithMeSavings.com**

*Signature *Date

Questions? Call 833-withMe1 (833-948-4631), Monday–Friday, 8:00 AM–11:00 PM ET

Mail:
TREMFYA withMe Savings Program
2250 Perimeter Park Drive, Suite 300
Morrisville, NC 27560

OR

Fax:
833-512-0495

You will receive your rebate check in about three weeks.

Please read the full Prescribing Information and Medication Guide for TREMFYA® and discuss any questions you have with your doctor.

Clear Form Print Form