

Janssen Patient Support Program Patient Authorization Form

Patients should **(1)** read the Patient Authorization, **(2)** check the desired permission boxes, and **(3)** return the form to Janssen Patient Support Program.

Options to complete and return the form:

- A. Download a copy, print, check the desired boxes, and sign. The completed form may be faxed to 866-279-0669 or mailed to Janssen CarePath, PO Box 826, South San Francisco, CA 94083.
- B. Patients may also read, sign, and submit a digital version of this form at PAHconsent.com.

Patient Name _____ Date of Birth (mm/dd/yyyy) _____

Patient Address _____

City _____ State _____ ZIP Code _____

Phone Number _____ 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.

My “Protected Health Information” includes but is not limited to the following 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 include foundations and co-pay assistance providers
- Service providers supporting or analyzing data from Janssen patient support programs

Specifically, 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, and contact me about Janssen patient support programs
- 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

Janssen Patient Support Program

Patient Authorization Form

- communicate with my Healthcare Providers regarding access to, reimbursement for and fulfillment of my Janssen medication, and to confirm to my Healthcare Provider that support has been provided by the 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

I understand that my Protected Health Information will not be used or shared by Janssen for any other use without my permission. Janssen may share information about me where legally allowed or if any information that specifically identifies me is removed. I understand that Janssen will make every effort to keep my information private. Further, I understand that if my information is accidentally shared, federal privacy laws do not require that the person/party receiving it not share the information further and that such information provided to a third party may no longer be protected by federal privacy laws. I understand that my pharmacy may receive compensation in connection with sharing my information with Janssen as allowed under this Authorization.

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.

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.

Janssen Patient Support Program Patient Authorization 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 826, South San Francisco, CA 94083

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 sign here: _____ **Date:** _____

If 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:
