

Guide to Electronic Patient Authorization

Once you and your healthcare provider have decided that a Janssen medication is right for you, Janssen CarePath will help you find the resources you may need to get started and stay on track.

In order to receive Janssen PAH patient support services from Janssen CarePath, you must read, sign, and submit the Patient Authorization Form. A convenient way to provide Patient Authorization online is through [PAHconsent.com](https://www.pahconsent.com).

Get
started



**Call a Janssen CarePath
Care Coordinator**

at 866-228-3546, Monday–Friday,
8:00 AM–8:00 PM ET. You can
request a unique, pre-verified link
to [PAHconsent.com](https://www.pahconsent.com)

OR



Visit [PAHconsent.com](https://www.pahconsent.com)

Steps for completing
on your own are outlined
on the following pages

What is [PAHconsent.com](https://www.pahconsent.com)?

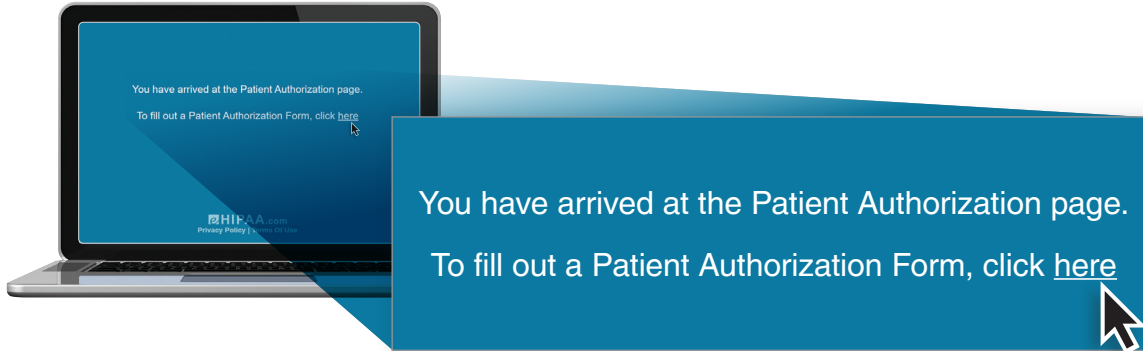
[PAHconsent.com](https://www.pahconsent.com) is an eHIPAA.com-powered portal that enables you to complete, sign, and submit a digital version of the Janssen Patient Support Program Patient Authorization Form. A completed Patient Authorization Form allows the exchange of Personal Health Information with Janssen CarePath in compliance with the Health Insurance Portability and Accountability Act (HIPAA).

See step-by-step instructions on the following pages.

Follow these steps to electronically sign the Patient Authorization from a smartphone, tablet, or computer:

STEP 1 Visit PAHconsent.com

Click “here” to begin the process of filling out the **Patient Authorization Form**.



STEP 2 Complete the Form

About This Form

This form will allow you to review the Patient Authorization Form and provide your authorization with an electronic signature. Please fill out the information below to get started. The information you provide will be used by CareMetx, LLC, our affiliates, and our service providers, for your registration and participation in this program. Our [Privacy Policy](#) further governs the use of the information you provide. By providing the information and selecting the Next button, you indicate that you read, understand, and agree to these terms.

Patient Information

First Name * Last Name *

Date of Birth * Gender

Address 1 *

Address 2

City *

State Zip Code *

I am signing as parent or guardian (personal representative) of the patient.

Personal Representative Information

First Name * Last Name *

Phone Number * Relationship

Contact Information

Email Address *

Patient Cell #

Need Help?
Phone:

[Privacy Policy](#) | [Terms Of Use](#)

Fill in all information, including Email Address, to verify your identity. (Email address is required for verification; see Step 3.)

When finished, click Next.

STEP 3 Email Address Confirmation

Note: If you are completing the form using the pre-verified link sent to you by email from Janssen CarePath, you will not need to complete this step.

Email Address Confirmation

Thank you for entering the patient information. Before you review and sign the Patient Authorization, we will send a verification code to your email address.

Please click on the button below to send the verification code.

Click the button to **Send Verification Code**. You will receive a unique code at the email address provided in Step 2.

Email Address Confirmation

eHIPAA just sent a verification code to your email. Enter that code below and click Next.

Didn't get the message? [Resend Verification Code](#)

Enter the 6-digit **Verification Code** sent via email and click **Next** to view and sign the Patient Authorization Form.

STEP 4 Review Authorization and Select Electronic Signature Type

Read the **Authorization** statement.

Authorization

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
- 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 as written in this Form to:

- My Insurers
- My Healthcare Providers
- Any of the persons given information as mentioned
- Any individual I give permission to

I understand that my Protected Health Information may be used for other purposes not mentioned above. I understand that Janssen may use my Protected Health Information for other purposes not mentioned above. I understand that Janssen may use my Protected Health Information for other purposes not mentioned above. I understand that Janssen may use my Protected Health Information for other purposes not mentioned above. I understand that Janssen may use my Protected Health Information for other purposes not mentioned above.

I understand that I am not required to sign this Form, and I understand that I may 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.

Signature of Patient

Type Your Name
Jane Doe

Date
01/19/2021

Signature Options:

Jane Doe

I understand that this is a legal representation of my signature.

Type in your **Name** and the **Date**.

Select either **Typed Signature** or **Draw Signature** option.

Then click **Next**.

! Almost done! Your Patient Authorization isn't complete until you navigate through Step 6, where you'll submit your authorization and choose if you want to download a copy.

STEP 5 Optional Patient Consents to Consider

Optional Patient Consents

Please review the language below and check the boxes for the consents to which you wish to opt in.

Yes, I would like to receive communications relating to my Janssen medication.
Permission for communications outside of Janssen patient support programs. 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>.

Yes, I would like to receive communications relating to other Janssen products and services.
Permission for communications outside of Janssen patient support programs. 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>.

Yes, I would like to receive text messages.
Permission for text communications. 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 _____

(Optional) You may find it helpful to receive additional resources from Janssen:

- Checking the first box authorizes Janssen to send you information and updates relating to your prescribed Janssen medication
- Checking the second box authorizes Janssen to send communications relating to other Janssen products and services including other Janssen PAH products and services

You may call Janssen CarePath at any time with questions or to opt out of the communications described.

(Optional) To receive support, reminder, and educational text messages from Janssen CarePath, check the box and provide your cell phone number.

For example, checking this box allows Janssen patient support teams to let you know they'll be contacting you by phone, so you will know to expect their call.

Click **Next** to proceed to the final step.

STEP 6 Final Review and Confirmation

Review and Confirm

**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 Jane Doe Date of Birth (mm/dd/yyyy) 10/30/2000
 Patient Address 123 Any Street
 City Anytown State VA ZIP Code 99999
 Phone Number (444) 444-4444 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"):

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By clicking Complete, I affirm that I am authorized to sign this form and understand and agree that the electronic signature on this form has the same effect as my handwritten signature. I further acknowledge that I have read the document in its entirety and intend to be bound by the terms and conditions contained within. In the event I encounter difficulty in obtaining a copy of this form, I understand I may email support@ehlpaa.com for assistance.

Make Changes
Complete

Complete a final review of the Patient Authorization and check the blue box to confirm.

To submit, click **Complete**.

That's it! No further action is required.

You can save or email a copy of the completed form for your records.



Need help?

Call **866-228-3546**
 Monday–Friday, 8:00 AM–8:00 PM ET
 Multilingual phone support available