1. **OPTIONAL:** This form is optional. Signing this form is not required for a patient to receive medical treatment, to start or stay on therapy, or to be enrolled in Janssen CarePath Savings Program.
2. **AUTHORIZATION:** By signing this form, the patient authorizes Janssen CarePath Savings Program to issue payment directly to their provider for any reimbursement amounts attributable to the costs of medication administered in their provider’s office. This form grants patient authorization for all of the patient’s treatment providers who submit a rebate request to Janssen CarePath Savings Program.
3. **INSTRUCTIONS:** Patient must read this form, complete all fields, sign, and upload the form to their Patient Account at [**MyJanssenCarePath.com**](https://www.myjanssencarepath.com/s/login/?startURL=%2FPatientLanding%3Fprod%3Dundefined). Providers may also upload the completed form to the Provider Portal **(**[**JanssenCarePathPortal.com**](https://www.janssencarepathportal.com/s/login/SelfRegister)**)**.
4. **CANCELLATION:** Patient may, at any time, call Janssen CarePath at 877-CarePath (877-227-3728), and cancel their Assignment of Benefits.

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| **Patient Authorization** |
| The information you provide will be used by Johnson & Johnson Health Care Systems Inc., our affiliates, and our service providers ("Janssen CarePath") to perform services related to Janssen CarePath. Our [**Privacy Policy**](https://www.myjanssencarepath.com/s/privacypolicy) further governs the use of information you provide. By providing the information and signing below, you indicate that you read, understand, and agree with these terms. You also understand that you may, at any time, call Janssen CarePath and cancel this Assignment of Benefits. Upon cancellation, payment will no longer be sent directly to your provider(s) and will be sent to you or loaded to your Janssen CarePath Savings Program card. |  |
| Patient Name: |       | Date of Birth (mm/dd/yyyy): |       |  |
| Janssen CarePath Savings Program Member # (OPTIONAL): |       |  |
| (from Savings Program card) |  |
|  |  |
| Patient Address: |       |  |
| City:  |       | State:  |    | ZIP Code:  |       |  |
| **Patient Signature:** |  | 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: |  |  |
|  |       |  |
|  |