Janssen CarePath

Prescription Enrollment Form

Complete and fax this form to Janssen CarePath at 833-200-6306.

Ponvory™ (ponesimod) tablets

The information you provide will be used by Janssen Pharmaceuticals, Inc., our affiliates, and our service providers for the patient's enrollment and participation in Janssen CarePath, a Janssen Patient Support Program offering access, affordability, and treatment support for patients. You may withdraw by calling 877-CarePath (877-227-3728). Our **Privacy Policy** further governs the use of the information you provide. By providing the information and submitting this form, you indicate that you read, understand, and agree to these terms.

Janssen CarePath cannot accept any information without a completed Patient Authorization Form, which can be found on the last two pages of this document or electronically signed at MyJanssenCarePath.com/PatientAuth.

1. PATIENT INFORMATION (Required)

PATIENT NAME (First, MI, Last) _____ SEX ☐ M ☐ F

DATE OF BIRTH (MM/DD/YYYY) _____ PREFERRED LANGUAGE: ☐ English ☐ Spanish ☐ Other _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

CELL PHONE (☐ preferred) _____ HOME PHONE (☐ preferred) _____ BEST TIME TO CONTACT: ☐ AM ☐ PM

EMAIL _____

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

NAME OF CARE PARTNER (if applicable) _____ RELATIONSHIP TO PATIENT _____

CARE PARTNER PHONE _____ ☐ If my patient cannot be reached, my patient authorizes Janssen CarePath to contact their care partner. ☐ My patient prefers and authorizes Janssen CarePath to contact the care partner in place of the patient.

2. INSURANCE INFORMATION (Required. Please fill out this section in its entirety or provide a copy of the front and back of insurance cards.)

PRIMARY PRESCRIPTION INSURANCE _____ CARD BIN # _____ PHONE _____

CARDHOLDER NAME (First, MI, Last) _____ RELATIONSHIP TO CARDHOLDER _____

POLICY # _____ GROUP # _____

PRIMARY MEDICAL INSURANCE _____ PHONE _____

CARDHOLDER NAME (First, MI, Last) _____ RELATIONSHIP TO CARDHOLDER _____

POLICY # _____ GROUP # _____

SECONDARY MEDICAL INSURANCE _____ PHONE _____

CARDHOLDER NAME (First, MI, Last) _____ RELATIONSHIP TO CARDHOLDER _____

POLICY # _____ GROUP # _____

3. CLINICAL INFORMATION (Required)

DIAGNOSIS: ☐ G35 (Multiple Sclerosis) ☐ Other ICD-10 Code _____

HAS PATIENT ALREADY INITIATED PONVORY™? ☐ YES, START DATE (MM/YYYY) _____ to _____ ☐ NO

CURRENT/MOST RECENT MS THERAPY: _____ (MM/YYYY) _____ to _____

OTHER MS THERAPY: _____ (MM/YYYY) _____ to _____

PLEASE LIST ANY KNOWN DRUG ALLERGIES: _____

4. PRIOR AUTHORIZATION

Prior Authorization Form Assistance and Status Monitoring: Janssen CarePath assists your office in providing the requirements of the patient's health plan related to prior authorization for treatment with PONVORY™. Assistance includes obtaining the health plan-specific prior authorization form, and providing it based upon the patient-specific information provided on this form. The partially completed prior authorization form, if received from the health plan, will be provided to your office for possible completion and submission in the office's sole discretion. Janssen CarePath also actively monitors the status of prior authorization submission to the patient's plan and provides status updates to your office with respect to this patient's prior authorization for treatment with PONVORY™.

☐ **I do NOT wish to receive Prior Authorization Form Assistance or Status Monitoring. This opt-out does not apply if you are requesting the patient be enrolled in Janssen Link.**

☐ **Prior Authorization is already on file with the patient's plan for treatment with PONVORY™.**

5. JANSSEN LINK FOR PONVORY™ PROGRAM

Janssen Link, a program offered by Janssen CarePath, is for eligible patients with commercial insurance who have been prescribed PONVORY™ for an on-label FDA-approved indication. It enables patients to receive PONVORY™ at no cost if the patient has commercial insurance that has delayed or denied their treatment. See program requirements on page 3.

☐ By checking this box and signing the prescription on page 2, I agree to enrolling my patient in the Janssen Link program. By enrolling patients in Janssen Link, I agree to complete and submit a form of coverage determination (ie, prior authorization or prior authorization with an exception) to the commercial insurance. If coverage is denied, then I agree to challenge the coverage denial with an exception, Letter of Medical Necessity, or appeal within 90 days. I also understand that Janssen CarePath will monitor prior authorization status.

Please see full Prescribing Information and Medication Guide for PONVORY™. Provide the Medication Guide to your patients and encourage discussion.

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Ponvory™ (ponesimod) tablets

PATIENT FIRST NAME: _____ **PATIENT LAST NAME:** _____ **DOB:** _____

6. PRESCRIBER INFORMATION (Required)

PRESCRIBER NAME (FIRST, LAST) _____

SITE NAME _____ SITE CONTACT _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMAIL _____ PHONE _____ FAX _____

NPI # _____ STATE LICENSE # (optional) _____ TAX ID # _____ PTAN (optional) _____

7. PRETEST ATTESTATION (Required when pretests are complete)

☐ By checking this box, I attest that I have assessed the following based on individual patient needs: Complete Blood Count, Cardiac Evaluation, Liver Function Tests, Ophthalmic Evaluation, Current or Prior Medications with Immune System Effects, and Vaccinations. This patient is cleared to initiate therapy with PONVORY™.

First Dose Monitoring is (please check one):

☐ Not required ☐ Required. I confirm I have counseled my patient on first dose monitoring requirements as described in the Prescribing Information.

8. IN-HOME PRETEST PROGRAM AND SCHEDULING SUPPORT

Eligible patients with commercial insurance can receive in-home support for pretests at no cost*. See full program requirements at JanssenCarePath.com.

☐ I would like Janssen CarePath to check my patient's eligibility for and enroll my patient into the In-Home Pretest Program† for the pretests I select below:

☐ CBC, including lymphocyte count ☐ LFTs (transaminase & bilirubin) ☐ VZV antibody serology ☐ Electrocardiogram (ECG) ☐ Ophthalmic evaluation

*The In-Home Pretest Program is only for pretests needed before the first time your patient starts treatment with PONVORY™. Not valid for patients with Medicare, Medicaid, or other government-funded programs for medical insurance coverage. Terms expire at the end of each calendar year and may change. Not valid for residents of MA, MI, MN, or RI. The ophthalmic evaluation is only available in select areas.

† If the patient is not enrolled in or not eligible for the In-Home Pretest Program, Janssen CarePath can help schedule appointments for the pretests selected above at Providers indicated by you or your patient.

9. PRESCRIPTION INFORMATION

TRIAL OFFER FOR PONVORY™ (Dispensed by Labcorp Specialty Pharmacy Only)

☐ **Trial Offer:** By checking this box, I indicate that I would like to enroll my patient in the Trial Offer program. I understand that the patient may be contacted by Labcorp Specialty Pharmacy, on behalf of Janssen CarePath, to initiate therapy and schedule shipping of his/her medication.

- Dispense one PONVORY™ Starter Pack (14 tablets/pack); follow titration schedule on pack starting with Day 1.
- Dispense one PONVORY™ 20-mg bottle (30 tablets/bottle); 1 tablet taken orally once a day starting after completion of Starter Pack.

PHARMACY PRESCRIPTION (Complete this section if requesting enrollment in Janssen Link for PONVORY™ AND/OR a pharmacy prescription)

For Patients that are restarting or not receiving the Trial Offer:

☐ Dispense one PONVORY™ Starter Pack (14 tablets/pack); follow titration schedule on pack starting with Day 1.

PONVORY™ 20 mg once daily:

☐ Dispense one PONVORY™ 20-mg bottle (30 tablets per bottle), 1 tablet taken orally once a day. REFILLS: _____

☐ Dispense three PONVORY™ 20-mg bottles (30 tablets per bottle), 1 tablet taken orally once a day. REFILLS: _____

SHIP TO‡:

☐ Patient (see page 1) ☐ Prescriber (see above)

☐ First dose monitoring site (Input address below or leave blank and a Janssen CarePath Care Coordinator will call you.)

SITE NAME _____ SITE CONTACT _____ PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

‡Confirmation that all pretests are completed will be required prior to shipping.

PRESCRIBER SIGNATURE REQUIRED TO VALIDATE PRESCRIPTION: I certify that therapy with PONVORY™ is medically necessary for this patient. I will be supervising the patient's treatment accordingly, and I have reviewed the current PONVORY™ full Prescribing Information. I authorize Janssen CarePath to act on my behalf for the limited purposes of transmitting the above prescription(s) by any means under applicable law to the appropriate pharmacy(ies) designated by me, the patient, or the patient's plan. PRESCRIBER SIGNATURE REQUIRED TO VALIDATE PRESCRIPTIONS. Prescriber attests this is his/her legal signature (NO STAMPS).

PRESCRIBER SIGNATURE _____ Dispense as Written **PRESCRIBER SIGNATURE** _____ Substitution Allowed DATE _____

10. PREFERRED PHARMACY

I have discussed preference for a Specialty Pharmacy (SP) with this patient. This patient prefers use of the SP indicated below. I authorize Janssen Pharmaceuticals, Inc., and its representatives to fax this prescription to: **1.** The SP designated below, provided it is approved by this patient's plan. **2.** If the SP designated is not a plan-approved SP, then to an SP preferred by this patient's plan. **3.** If there is no preferred SP indicated, then to any SP approved by this patient's plan.

PREFERRED SPECIALTY PHARMACY _____

Please see full Prescribing Information and Medication Guide for PONVORY™. Provide the Medication Guide to your patients and encourage discussion.

Patient insurance benefits investigation and other Janssen CarePath program offerings are provided by third-party service providers for Janssen CarePath, under contract with Johnson & Johnson Health Care Systems Inc. on behalf of Actelion Pharmaceuticals US, Inc., Janssen Biotech, Inc., Janssen Pharmaceuticals, Inc., and Janssen Products, LP (Janssen). Janssen CarePath is not available to patients participating in the Patient Assistance Program offered by Johnson & Johnson Patient Assistance Foundation. The availability of information and assistance may vary based on the Janssen medication, geography and other program differences. Janssen CarePath assists healthcare providers (HCPs) in the determination of whether treatment could be covered by the applicable third party payer based on coverage guidelines provided by the payer, and patient information provided by the HCP under appropriate authorization following the provider's exclusive determination of medical necessity. This information and assistance are made available as a convenience to patients, and there is no requirement that patients or HCPs use any Janssen product in exchange for this information or assistance. Janssen assumes no responsibility for and does not guarantee the quality, scope, or availability of the information and assistance provided. The third-party service providers, not Janssen, are responsible for the information and assistance provided under this program. Each HCP and patient is responsible for verifying or confirming any information provided. All claims and other submissions to payers should be in compliance with all applicable requirements.

Janssen Link for PONVORY™

Janssen Link for PONVORY™ enables eligible patients to receive PONVORY™ (ponesimod) at no cost until they receive coverage or for up to 24 months from program enrollment, whichever comes first, if these requirements are met. See program requirements below and on the previous page.

Janssen Link for PONVORY™ Program Requirements

- Patient has been prescribed PONVORY™ for an on-label, FDA-approved indication
- Patient has commercial insurance that has delayed (>5 business days) or denied their treatment
- Patient does not use any state or federal government-funded healthcare program to cover medication costs. Examples of these programs are Medicare, Medicaid, TRICARE, Department of Defense, and Veterans Administration
- Patient cannot submit the value of the free product as a claim for payment to any health plan
- Patient is not eligible if the prior authorization is denied due to missing information on coverage determination form, use for a non-FDA-approved indication or invalid clinical rationale
- Patient has signed a Janssen Patient Support Program Patient Authorization Form
- Patient must contact the program if the patient switches from commercial health insurance to a government-funded healthcare program

How Janssen Link for PONVORY™ Works

- Patients are eligible until they receive coverage or for up to 24 months of coverage from program enrollment, whichever comes first
- Program covers the cost of therapy only - not any associated assessments including pretests, first dose observations, or administration costs
- The value of the free product will not count towards the patient's out-of-pocket cost-sharing obligations
- Program good only in the United States and its territories. Void where prohibited, taxed, or limited by law
- Program terms may change

By participating in Janssen Link for PONVORY™, I authorize Janssen CarePath to:

- Conduct a benefits investigation and confirm prior authorization requirements
- Provide prior authorization form assistance and status monitoring, including the exceptions and appeals processes
- Coordinate shipment of PONVORY™ from the program Specialty Pharmacy to eligible patients at no charge until they receive coverage or for a maximum of 24 months from program enrollment, whichever comes first
- Support the transition of patients to commercial product if the medication is covered
- Check insurance coverage annually for patients enrolled in the program and any time for patients who have coverage change to confirm they are still eligible for the program

Please see full Prescribing Information and Medication Guide for PONVORY™. Provide the Medication Guide to your patients and encourage discussion.

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 Janssen Patient Support Program**
  - **Completed form may be faxed to 833-200-6306 or mailed to Janssen CarePath, PO Box 13135, La Jolla, CA 92037**

Patient Name _____ **Email** _____

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

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, PO Box 13135, La Jolla, CA 92037.

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: _____ **Date:** _____

(Signature of person legally authorized to sign for patient)

Describe relationship to patient and authority to make medical decisions for patient:

_____