

Janssen CarePath cannot accept any information without an executed Business Associate Agreement or Patient Authorization Form, which can be found at [JanssenCarePath.com](http://JanssenCarePath.com).

The information you provide will be used by Janssen Biotech, Inc., our affiliates, and our service providers for your patient's enrollment and participation in Janssen CarePath. Our [Privacy Policy](#) governs the use of the information you provide. By submitting this form, you indicate that you read, understand, and agree to these terms.

## 1. PRESCRIBER INFORMATION (REQUIRED)

Prescriber name \_\_\_\_\_  
 Practice name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
 Phone \_\_\_\_\_ Fax \_\_\_\_\_  
 Office contact name \_\_\_\_\_ Ext. \_\_\_\_\_  
 Provider specialty \_\_\_\_\_  
 Provider # (as it pertains to commercial insurance below) \_\_\_\_\_  
 Medicaid/Medicare provider # \_\_\_\_\_  
 Tax ID # \_\_\_\_\_ UPIN/NPI # \_\_\_\_\_

### Are you the prescribing specialist? (REQUIRED)

Yes  No (If No, complete section 1B)

### 1B. Name of Referring Specialist

Referring physician specialty \_\_\_\_\_

## 2. PATIENT INFORMATION (REQUIRED)

Name (First, MI, Last) \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
 Home phone \_\_\_\_\_  
 DOB (MM/DD/YYYY) \_\_\_\_\_ Gender  Male  Female

## 3. INSURANCE INFORMATION (REQUIRED)

(Fax copy of enlarged patient insurance card(s) or provide the information below)

Insurance company #1 \_\_\_\_\_  
 Primary insured name \_\_\_\_\_  
 Employer \_\_\_\_\_  
 Insurance company phone \_\_\_\_\_  
 Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
 (Please include alpha prefix and suffix where applicable)

Insurance company #2 \_\_\_\_\_  
 Primary insured name \_\_\_\_\_  
 Employer \_\_\_\_\_  
 Insurance company phone \_\_\_\_\_  
 Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
 (Please include alpha prefix and suffix where applicable)

Is patient a dependent of the insured (child <18 yrs; student >18 yrs)? Check if yes.

Please investigate out-of-network benefits

## 4. CLINICAL INFORMATION (REQUIRED. Visit [JanssenCarePath.com](http://JanssenCarePath.com) for ICD-10 codes or consult the ICD-10 code book for additional information)

REMICADE®  Infliximab

### Primary Diagnosis:

Diagnosis Code \_\_\_\_\_ Indication \_\_\_\_\_

### Secondary Diagnosis:

Diagnosis Code \_\_\_\_\_ Indication \_\_\_\_\_

### Comment/Other

\_\_\_\_\_

### Date of diagnosis or years with disease

Previous TB test (date) \_\_\_\_\_ Hepatitis B Virus test (date) \_\_\_\_\_

Dosage/frequency \_\_\_\_\_

Patient weight \_\_\_\_\_ lb. \_\_\_\_\_ kg. # of vials to be used \_\_\_\_\_

Anticipated # of infusions \_\_\_\_\_

Number of prior infusions  unknown  0  1-3  4+

Scheduled date of infusion \_\_\_\_\_

## 5. MEDICATIONS (Specify current dosage and time on therapy)

Therapy	Dosage	P = Prior C = Current F = Failure	Months		
			<3	3-6	>6
<input type="checkbox"/> 5-ASA	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Azulfidine®	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Azathioprine	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 6-MP	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Prednisone	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Methotrexate	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cyclosporine	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Retinoids	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Gold compounds	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hydroxychloroquine	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cyclophosphamide	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Penicillamine	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Leflunomide	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Enbrel®	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Kineret®	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Humira®	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Orencia®	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Rituxan®	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Phototherapy	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other: _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## 6. PRIOR AUTHORIZATION

If you would like Janssen CarePath to provide support for the prior authorization process, please check the appropriate box(es):

Prior Authorization Form Assistance

By checking this box, I request that Janssen CarePath assist my office in providing the requirements of this patient's health plan related to prior authorization for treatment with REMICADE® or Infliximab. I understand that assistance includes obtaining the health plan-specific prior authorization form, and providing it based upon the patient-specific information provided on this form. I understand that the partially completed prior authorization form will be provided to my office by Janssen CarePath for possible completion and submission in the office's sole discretion.

Prior Authorization Status Monitoring

By checking this box, I request that Janssen CarePath actively monitor the status of the prior authorization submission. I request that Janssen CarePath provide status updates to my office with respect to this patient's prior authorization for treatment with the medication specified.

## 7. PREFERRED SITE OF INFUSION (REQUIRED)

Prescribing MD's office  Non-prescribing MD's office  Other

Hospital outpatient  Home infusion/Infusion Provider Company

(Fields below do not need to be completed if information is the same as in section 1)

Physician or infusion provider name \_\_\_\_\_

Physician specialty \_\_\_\_\_

Practice/facility name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Contact name \_\_\_\_\_

Insurance provider # \_\_\_\_\_ Tax ID # \_\_\_\_\_

Third-party trademarks used herein are trademarks of their respective owners.

Please see full Prescribing Information, including Boxed Warnings, and Medication Guides for [REMICADE®](#) and [Infliximab](#). Provide the appropriate Medication Guide to your patients and encourage discussion.

Information about your patient's insurance coverage, cost support options, and treatment support is given by service providers for Janssen CarePath. The information you get does not require you or your patient to use any Janssen product. Because the information we give you comes from outside sources, Janssen CarePath cannot promise the information will be complete. Janssen CarePath is not for patients in the Johnson & Johnson Patient Assistance Foundation.