Janssen CarePath UPDATE 11.21

Benefits Investigation and Prescription Form

Complete and fax this Form to 855-224-5072 or mail to 2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560.
For assistance, call 877-CarePath (877-227-3728), Monday–Friday, 8:00 AM–8:00 PM, ET

Remicade® INFLIXIMAB | Infliximab | Simponi® golimumab

Janssen CarePath cannot accept any information without an executed Business Associate Agreement or Patient Authorization Form, which can be found at JanssenCarePath.com or as the last two pages of this document.

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. PATIENT INFORMATION (REQUIRED)

NAME (First, MI, Last) _____ SEX ☐ M ☐ F
DOB (MM/DD/YYYY) _____ ADDRESS _____
CITY _____ STATE _____ ZIP CODE _____ E-MAIL _____
CELL PHONE _____ HOME PHONE _____ WORK PHONE _____
PREFERRED NUMBER TO CALL ☐ Cell ☐ Home ☐ Work BEST TIME TO CONTACT ☐ Morning ☐ Afternoon ☐ Evening

2. INSURANCE INFORMATION (REQUIRED. Include alpha prefix and suffix with policy and group# when applicable or provide a copy of insurance cards)

PRIMARY INSURANCE _____ CARDHOLDER _____
RELATIONSHIP TO CARDHOLDER _____ EMPLOYER _____ INS. CO. PHONE _____
POLICY # _____ GROUP # _____
SECONDARY INSURANCE _____ CARDHOLDER _____
RELATIONSHIP TO CARDHOLDER _____ EMPLOYER _____ INS. CO. PHONE _____
POLICY # _____ GROUP # _____
PRESCRIPTION DRUG INSURER _____ CARD/BIN # _____ PHONE _____

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

☐ **PLEASE INVESTIGATE OUT-OF NETWORK BENEFITS FOR REMICADE® or Infliximab**

NOTE: For SIMPONI®, pharmacy benefit will be investigated. If patient does not have a pharmacy benefit, medical benefits will be investigated.

3. PRIOR MEDICATIONS (REQUIRED. Specify—P=Prior, C=Current, F=Failure)

☐ 5-ASA _____ ☐ Azathioprine _____ ☐ Cimzia® _____ ☐ Cyclosporine _____ ☐ Methotrexate _____
☐ 6-MP _____ ☐ Azulfidine® _____ ☐ Corticosteroids _____ ☐ Humira® _____ ☐ Other _____

4. PRESCRIBER INFORMATION (REQUIRED)

PRESCRIBER NAME (First, Last) _____
SPECIALTY _____
PRACTICE NAME _____ OFFICE CONTACT _____
ADDRESS _____
CITY _____ STATE _____ ZIP CODE _____
E-MAIL _____ PHONE _____ FAX _____
MEDICAID/MEDICARE PROVIDER # _____ TAX ID # _____
STATE LICENSE # _____ UPIN/NPI # _____
Are you the prescribing specialist? (Required) ☐ YES ☐ NO: IF NO, REFERRING SPECIALIST _____
REFERRING PHYSICIAN SPECIALTY _____

5. CLINICAL INFORMATION (REQUIRED. Visit JanssenCarePath.com for ICD-10 codes or consult the ICD-10 code book for additional information)

☐ **REMICADE®** or ☐ **Infliximab—DIAGNOSIS: Crohn's Disease, Fistula (Secondary to Crohn's Disease), Ulcerative Colitis**

DIAGNOSIS CODE _____ INDICATION _____
DOSAGE/FREQUENCY _____ NUMBER OF PRIOR REMICADE® OR Infliximab INFUSIONS ☐ unknown ☐ 0 ☐ 3 ☐ 4+
OF VIALS TO BE USED _____ ANTICIPATED # OF INFUSIONS _____

☐ **SIMPONI®—DIAGNOSIS: Ulcerative Colitis**

DIAGNOSIS CODE _____ INDICATION _____

■ **ADDITIONAL CLINICAL INFORMATION**

DATE OF DIAGNOSIS OR YEARS WITH DISEASE _____ PATIENT WEIGHT _____ lb. _____ kg.
PREVIOUS TB TEST (DATE) _____ HEPATITIS B VIRUS TEST (DATE) _____ SCHEDULED DATE OF INFUSION _____

6. PRESCRIPTION INFORMATION: Rx: SIMPONI® (If requesting benefits investigation only, do not complete this section. The prescription is only valid if received by fax. If not faxed, prescription must be submitted on state-specific blank, if applicable for your state)

DIRECTIONS: **STARTER DOSES**

☐ 200 mg at Week 0; 2 single-use autoinjectors, 100 mg/1.0 mL SC ☐ 100 mg at Week 2; 1 single-use autoinjector, 100 mg/1.0 mL SC
☐ 200 mg at Week 0; 2 single-use prefilled syringes, 100 mg/1.0 mL SC ☐ 100 mg at Week 2; 1 single-use prefilled syringe, 100 mg/1.0 mL SC

MAINTENANCE THERAPY

☐ 1 single-use autoinjector, 100 mg/1.0 mL SC every 4 weeks ☐ 1 single-use prefilled syringe, 100 mg/1.0 mL SC every 4 weeks Refills # _____
☐ OTHER _____ Refills # _____

■ **PRESCRIBER SIGNATURE (NO STAMPS ALLOWED) REQUIRED TO VALIDATE PRESCRIPTION:** **I certify that therapy with SIMPONI® is medically necessary for this patient. I will be supervising the patient's treatment accordingly, and I have reviewed the current SIMPONI® Prescribing Information. I authorize Janssen CarePath to act on my behalf for the limited purposes of transmitting this prescription to the appropriate pharmacy designated by me, the patient, or the patient's plan.**

PRESCRIBER SIGNATURE (Dispense as Written) _____ DATE _____
SUPERVISING PHYSICIAN SIGNATURE (if applicable) _____ DATE _____
SUPERVISING PHYSICIAN NAME _____

7. REMICADE® or Infliximab PREFERRED SITE OF INFUSION (REQUIRED)

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

☐ Prescribing MD's office ☐ Non-prescribing MD's office ☐ Hospital outpatient ☐ Home infusion/Infusion Provider Company ☐ Other
PHYSICIAN OR INFUSION PROVIDER NAME _____
PRACTICE/FACILITY NAME _____
ADDRESS _____
CITY _____ STATE _____ ZIP CODE _____
PHONE _____ FAX _____ CONTACT NAME _____
INSURANCE PROVIDER # _____ TAX ID # _____

8. SHIPPING INFORMATION FOR SIMPONI® (REQUIRED to complete benefits investigation even if not prescribing. NOTE: Shipments cannot be sent to P.O. Boxes)

SHIP TO: ☐ PROVIDER OFFICE—Initial injection only
☐ PATIENT'S HOME—I have instructed the patient in proper injection technique for SIMPONI® and the patient will self-administer ☐ OTHER
NAME (if different than above) _____
ADDRESS _____ CITY _____ STATE _____
ZIP CODE _____ PHONE _____ FAX _____

9. PREFERRED SPECIALTY PHARMACY (Provider to check one below)

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

☐ Accredo ☐ Amber ☐ BioPlus ☐ BriovaRx ☐ CVS Caremark ☐ Cigna ☐ Diplomat ☐ Humana
☐ Kroger ☐ Senderra ☐ AllianceRx ☐ Other _____

10. PRIOR AUTHORIZATION (Please check the appropriate box[es] below to request assistance with prior authorizations)

☐ **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 specified medication.

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

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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.

janssen
PHARMACEUTICAL COMPANIES OF
Johnson & Johnson

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.

- **Download a copy, print, check the desired boxes, and sign. Your healthcare provider may scan the completed Form and upload on Provider Portal, or completed Form may be faxed to 855-224-5072 or mailed to Janssen CarePath, 2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560**
- **You may be able to eSign a digital Form in your healthcare provider's office or on the Janssen CarePath Patient Account at MyJanssenCarePath.com**

Patient Name: _____ **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 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 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.

Janssen Patient Support Program Patient Authorization Form

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, 2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560.

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:

_____

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