



Savings Program Patient Enrollment Form



The information you provide will be used by Johnson & Johnson Health Care Systems Inc., our affiliates, and our service providers to determine your eligibility for, and enroll you in, the Savings Program. In order to personalize the information you receive, the information you provide may be combined with information received from other sources, as described in our [Privacy Policy](#). Our [Privacy Policy](#) further governs the information you provide.

***Required**
***SELECT ONE:** Enrollment Update Information Only
 Phone: 877-CarePath (877-227-3728) Fax: 877-234-3048 MyJanssenCarePath.com

| PATIENT INFORMATION (*Required) | | |
|---|--|--|
| *Do you have a REMICADE® and Infliximab Mastercard®? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide 11-digit ID number at bottom of card: _____ | | |
| *NAME _____ | *SEX <input type="checkbox"/> Male <input type="checkbox"/> Female | *DATE OF BIRTH (MM/DD/YYYY) _____ |
| *ADDRESS _____ | *CITY _____ | *STATE _____ *ZIP CODE _____ |
| *PRIMARY PHONE (Best number to call 8:00 AM–8:00 PM ET, weekdays) _____ | EMAIL _____ | |
| *If you're unavailable when we call, is it okay for us to leave a message including the name of your medication? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Your rebate will be applied to a REMICADE® and Infliximab Mastercard to pay for your medication at your treatment provider or pharmacy. This card is not a credit card. There is no charge for this card. If your treatment provider or pharmacy DOES NOT ACCEPT the REMICADE® and Infliximab Mastercard, please call 877-CarePath (877-227-3728), Monday through Friday, 8:00 AM–8:00 PM ET, to discuss alternate payment options. | | |
| *1. Do you have commercial or private health insurance that you will use for your Janssen medication? Examples are commercial insurance from a former/current employer, government employee health insurance, or insurance you buy privately or through the Health Insurance Marketplace. <input type="checkbox"/> Yes, I have commercial or private health insurance that I will use for my Janssen medication <input type="checkbox"/> No, I do not have commercial or private health insurance that I will use for my Janssen medication | *2. Do you agree NOT to ask any government-funded healthcare program to cover any of the Janssen medication costs? Examples are Medicare Parts A, B, C (also known as Medicare Advantage Plan), D, and Medicare Supplement, Medicaid, TRICARE, Department of Defense, or Veterans Administration. <input type="checkbox"/> Yes, I agree that I will NOT seek payment from any government-funded healthcare program for my Janssen medication <input type="checkbox"/> No, I may seek payment from a government-funded healthcare program for my Janssen medication | *3. Do you agree NOT to submit any costs paid by this program as a claim for payment to any health plan, patient assistance foundation, flexible spending account, or healthcare savings account? <input type="checkbox"/> Yes, I agree that I will NOT submit any costs paid by this program as a claim <input type="checkbox"/> No, I may submit costs paid by this program as a claim |

I understand that if I am using medical/primary insurance to pay for my Janssen medication, I am responsible for submitting a rebate request including an Explanation of Benefits (EOB) to receive payment following each treatment. At my direction, my provider may submit the rebate request on my behalf. I will coordinate with my provider who will submit the rebate request. The Program will use the information my provider or I submit to determine the amount of costs for REMICADE® or Infliximab that Janssen Biotech, Inc., will reimburse. That amount will be credited to my REMICADE® and Infliximab Mastercard. I further understand that if my provider or I do not submit an EOB or pharmacy receipt, the Program cannot process my rebate request. I understand that I can use my Savings Program card for instant savings if REMICADE® or Infliximab is obtained from a pharmacy and that if the pharmacy is unable to process my Savings Program card, I will receive a rebate by submitting my pharmacy receipt. I understand that if a pharmacy provides REMICADE® or Infliximab to my treatment provider, and can accept REMICADE® and Infliximab Mastercard, the rebate for REMICADE® or Infliximab will be credited to my REMICADE® and Infliximab Mastercard to pay for REMICADE® or Infliximab at the pharmacy. By participating in the Savings Program, I am giving permission for information related to my Savings Program transactions, including rebates and any funds placed on or balance remaining on the Savings Program card, to be shared with my healthcare provider(s).

I understand that I can cancel participation in the Program at any time by notifying Janssen CarePath at 877-CarePath (877-227-3728). Our [Privacy Policy](#) governs the use of the information you provide. I understand that, if I am enrolled in the Program, Janssen Biotech, Inc., will not be responsible for lost or stolen cards or for any misuse of these cards.

| YOUR PRESCRIBER (*Required) | | | |
|---|--|--|--------------------------------|
| *PRESCRIBER NAME _____ | *PRACTICE NAME _____ | | |
| *ADDRESS _____ | *CITY _____ | *STATE _____ | *ZIP CODE _____ |
| *PHONE # _____ | *OFFICE-MAIN FAX # _____ | | |
| TREATMENT PROVIDER INFORMATION (This section does not need to be completed if information is the same as "YOUR PRESCRIBER") | | | |
| NAME OF PHYSICIAN _____ | OFFICE/HOSPITAL/OTHER NAME _____ | | |
| ADDRESS _____ | CITY _____ | STATE _____ | ZIP CODE _____ |
| PHONE # _____ | OFFICE-MAIN FAX # _____ | | |
| <input type="checkbox"/> Non-prescribing MD's Office | <input type="checkbox"/> Hospital Outpatient | <input type="checkbox"/> Home Treatment/Treatment Provider Company | <input type="checkbox"/> Other |

Fax or mail completed Enrollment Form to: **Fax: 877-234-3048 Mail: Janssen CarePath Savings Program, 2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560**

My signature below certifies that I have completed all of the above sections completely, accurately, and to the best of my knowledge. I understand, accept, and comply with all requirements and restrictions described in the eligibility requirements provided on pages 2 and 3 and I understand that redeeming this benefit is consistent with the requirements of my health plan.

| | | |
|--|------------|---|
| PATIENT SIGNATURE _____ | DATE _____ | PATIENT NAME _____ |
| If the patient cannot sign, patient's personal representative must sign below (Please print) | | |
| PATIENT NAME _____ | BY _____ | (Signature of person signing for patient) |
| RELATIONSHIP TO PATIENT AND AUTHORITY TO MAKE MEDICAL DECISIONS FOR PATIENT _____ | | |

Please read the full Prescribing Information, including Boxed Warning, and Medication Guides for [REMICADE®](#) and [Infliximab](#), and discuss any questions you have with your doctor.

For assistance or additional information, call 877-CarePath (877-227-3728), Monday–Friday, 8:00 AM–8:00 PM ET

3 ways to enroll: Review the program requirements below, then choose the enrollment option you prefer:



Online:
[MyJanssenCarePath.com](https://www.MyJanssenCarePath.com)



Phone:
877-CarePath (877-227-3728)



Form:
Complete and sign the previous page of this Form, and fax or mail to:
Fax: 877-234-3048 **OR** Mail: Janssen CarePath Savings Program
2250 Perimeter Park Drive, Suite 300
Morrisville, NC 27560

NOTE: Your signature on the previous page of this Form certifies:

- That you understand, accept, and comply with all requirements described below, and that your participation in the Program is consistent with the requirements of your health plan.

Savings Program Requirements

Am I eligible?

You may be eligible for the Janssen CarePath Savings Program if you are age 6 or older, use commercial or private health insurance for your prescribed REMICADE® (infliximab) or Infliximab, and must pay an out-of-pocket cost for your medication. There is no income requirement.

Some health plans have programs or benefit designs known as “accumulators” or “maximizers.” These programs divert patient assistance funds away from patients.

- Accumulators don’t allow patient assistance to count toward the patient’s deductible and out-of-pocket maximum until the maximum value of the patient assistance is reached.
- Maximizers also don’t allow patient assistance to count toward the patient’s deductible and out-of-pocket maximum. Maximizers apply the full value of the patient assistance over the year. This could be either the same amount each month or a larger amount early in the year that tapers off, without allowing any of those funds to count toward the patient’s annual deductible or out-of-pocket maximum.
- The Janssen CarePath Savings Program is designed solely for the benefit of the patient. Thus, Janssen reserves the right to reduce the Janssen CarePath Savings Program maximum benefit for patients in an accumulator or maximizer program or benefit design, except where prohibited by law.

In addition, some health plans have “non-essential health benefit maximizers” that conflict with the program requirements of the Janssen CarePath Savings Program.

- These programs or benefit designs, like the services offered by SaveOnSP, classify certain specialty medicines such as REMICADE® or Infliximab as “non-essential.” This takes away protections for patients provided by the Affordable Care Act (ACA) related to maximum out-of-pocket limits.
- The Janssen CarePath Savings Program is designed solely for the benefit of the patient. If your insurance company or health plan partners with SaveOnSP, then except where prohibited by law, you will not be eligible for, and you agree not to use, the Janssen CarePath Savings Program.
- Please let Janssen CarePath know if your insurance company or health plan has one of these programs or benefit designs, including SaveOnSP, by calling 877-CarePath (877-227-3728) to discuss your options. Since you may not know you are subject to one of these programs or benefit designs when you enroll in Janssen CarePath, Janssen will monitor your utilization.
- Janssen reserves the right to discontinue cost support if you no longer meet eligibility requirements.
- If your health plan removes REMICADE® or Infliximab from its partnership with SaveOnSP or other non-essential health benefit maximizer, you may be eligible to be reinstated in the Janssen CarePath Savings Program.

By utilizing this Savings Program, you accept and agree to abide by these program requirements. Any individual or entity who enrolls or assists in the enrollment of a patient in the Savings Program represents that the patient meets the eligibility criteria and other requirements described.

Janssen Biotech, Inc., is not liable for unintended or unauthorized use of the REMICADE® and Infliximab Mastercard® if it is lost or stolen. The Janssen CarePath Savings Program for REMICADE® and Infliximab Prepaid Mastercard is issued by Pathward®, N.A., Member FDIC, pursuant to license by Mastercard International Incorporated. Mastercard and the circles design are registered trademarks of Mastercard International Incorporated. Janssen CarePath Savings Program is not a Pathward or Mastercard product or service, nor is the optional offer endorsed by them.

Please read the full Prescribing Information, including Boxed Warning, and Medication Guides for [REMICADE®](#) and [Infliximab](#), and discuss any questions you have with your doctor.

Savings Program Requirements (cont'd)

Other requirements

- This program is only for people age 6 or older using commercial or private health insurance who must pay an out-of-pocket cost for their Janssen medication. This includes plans from the Health Insurance Marketplace. This program is not for people who use any state or federal government-funded healthcare program. Examples of these programs are Medicare, Medicaid, TRICARE, Department of Defense, and Veterans Administration.
- By enrolling in this program, you agree that this program is intended solely for the benefit of you, the patient. You may not seek payment for the value received from this program from any health plan, patient assistance foundation, flexible spending account, or healthcare savings account.
- You must meet the program requirements every time you use the Savings Program.
- Program terms will expire at the end of each calendar year. The program may change or end without notice, including in specific states.
- Program participants are subject to an annual maximum benefit. Program benefits are set at the discretion of Janssen and may change without notice.
- Patients who are subject to programs, health plans, or benefits that claim to **reduce** their patients' out-of-pocket co-pay, co-insurance, or deductible obligations for certain prescription drugs based upon the availability of, or patient's enrollment in, manufacturer-sponsored co-pay assistance for such drugs will be subject to a reduced annual maximum program benefit per calendar year (not applicable to patients in Maine).
- Patients who are subject to programs, health plans, or benefits that claim to **eliminate** their out-of-pocket costs are not eligible for the Janssen CarePath Savings Program, because this program is only for people who must pay an out-of-pocket cost for REMICADE® or Infliximab.
- Notwithstanding any other term of this program, patients who are members of health plans that partner with SaveOnSP, or who are subject to services administered by SaveOnSP, are not eligible for the Janssen CarePath Savings Program. If your health plan removes REMICADE® or Infliximab from its partnership with SaveOnSP, you may be eligible for the Janssen CarePath Savings Program.
- To use this program, you must follow any health plan requirements, including telling your health plan how much co-payment support you get from this program, if required. By using the Savings Program, you confirm that you have read, understood, and agree to the program requirements on this page, and you are giving permission for information related to your Savings Program transactions to be shared with your healthcare provider(s). These transactions include rebates and any funds placed on the card or balance remaining on the card.
- Before you enroll in the program, you will be asked to provide personal information that may include your name, address, phone number, email address, and information related to your prescription medication insurance and treatment. This information is needed for Janssen Biotech, Inc., the maker of REMICADE® and Infliximab, and our service providers to enroll you in the Janssen CarePath Savings Program. We may also use the information you give us to learn more about the people who use REMICADE® or Infliximab, and to improve the information we give them. Janssen Biotech, Inc., will not share your information with anyone else except where legally allowed.
- If you use medical/primary insurance to pay for your medication, you need to submit a rebate request with an Explanation of Benefits (EOB) to get payment from the Savings Program. With your permission, your provider may submit the rebate request and EOB for you. Please make sure you and your provider know who will submit the rebate request.
- This program offer may not be used with any other coupon, discount, prescription savings card, free trial, or other offer. Offer good only in the United States and its territories. Void where prohibited, taxed, or limited by law.

You may end your participation in Janssen CarePath at any time by calling 877-CarePath (877-227-3728).

Please read the full Prescribing Information, including Boxed Warning, and Medication Guides for **REMICADE®** and **Infliximab**, and discuss any questions you have with your doctor.

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 the 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 877-234-3048 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 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 pharmacies that dispense and ship my medication and service providers for the patient support programs may be paid by Janssen for their services and data. This may include payment for sharing Protected Health Information and other data in connection with these programs, 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: _____ Print name: _____ Date: _____

(Signature of person legally authorized to sign for patient)

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

