Janssen CarePath

Savings Program
877-CarePath (877-227-3728)
Monday–Friday, 8:00 AM–8:00 PM ET

Remicade® INFLIXIMAB | Infliximab

Medical Benefit Rebate Form

Complete this side of the form only if you are submitting an **Explanation of Benefits (EOB)** for a rebate check **to be sent directly to the patient.**

Receive a Rebate in 4 Easy Steps

1. The patient must be enrolled in the Janssen CarePath Savings Program before receiving a Janssen medication. Patient can enroll by calling 877-CarePath (877-227-3728) or online at MyJanssenCarePath.com.
2. Patient must complete the information below and sign the form.
3. Include a copy of the following documents:
   - Explanation of Benefits (EOB) from patient's primary insurance provider (as well as any secondary insurance provider, if applicable);
   - Receipt from the treatment provider indicating proof of payment of patient's out-of-pocket Janssen medication costs. A valid receipt will include patient name, medication (name, J code, and NDC# are all required), date, and amount of out-of-pocket responsibility paid for patient's medication.

   If patient does not have proof of payment for the medication, patient must obtain their site representative's signature below.
4. Submit this form online (if site representative signature is required), by fax, or by mail along with EOB and proof of payment (see below for details). Patient should only submit this form online if site representative signature is required for proof of payment. Eligible patients will receive a rebate check in about three weeks.

If you are submitting a **pharmacy receipt** and want to receive a rebate check, only complete the Pharmacy Benefit Rebate Form on the next page.

Complete the information below. *Required

The information you provide will only be used by Janssen Biotech, Inc., our affiliates, and our service providers to provide benefits to you related to your participation in the Janssen CarePath Savings Program for REMICADE® and Infliximab. If you want to stop receiving this information or service, you may withdraw from the program by calling 877-CarePath (877-227-3728). Our **Privacy Policy** governs the use of the information you provide.

☐ By providing consent, you agree to the collection and use of your Sensitive Personal Information (SPI). Examples of SPI may include, but are not limited to, health-related information. We use this information consistent with our Privacy Policy, including to personalize the information you receive, fulfill any requests you submit, and to research, develop, and improve our products and services. By checking the box, you indicate that you read, understand, and agree to such collection and use of your SPI.

*Name _____ E-mail _____ *Phone _____

*11-digit ID# found on the front of the savings card _____ *Date of Birth (mm/dd/yyyy) _____ Sex ☐ Male ☐ Female

*Address _____ *City _____ *State _____ *ZIP _____

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. 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. 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, 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. Offer good only in the United States and its territories. Void where prohibited, taxed, or limited by law. REBATE FORM CANNOT BE BOUGHT, TRANSFERRED, OR SOLD. REBATE FORM CANNOT BE COMBINED WITH ANY OTHER OFFER, DISCOUNT, PRESCRIPTION SAVINGS CARD, OR FREE TRIAL. Use of this program is subject to the program requirements, which can be found at Remicade.JanssenCarePathSavings.com.

By signing, dating, and submitting this form, you confirm that **you:**

- **have enrolled in the Janssen CarePath Savings Program and received your savings card. Note: Janssen CarePath cannot process this rebate form if you have not yet received your Savings Program card; and**
- meet the program requirements of the Savings Program, which may also be found at Remicade.JanssenCarePathSavings.com.

*Patient Signature _____ *Date _____

Site representative signature required ONLY if proof of payment is not provided with rebate request. By signing below, you are confirming the patient has paid for their out-of-pocket medication costs and was treated with (select one) ☐ REMICADE®: NDC 57894-030-01 or ☐ Infliximab: NDC 57894-160-01 on the date below.

*Site Representative Signature _____ *Print Name _____ *Date _____

*Treatment Site Name/Location _____ *Date of Treatment _____

You can submit online, by fax, or by mail:

Online:
MyJanssenCarePath.com
Patient should only submit this form online if site representative signature is required for proof of payment.

Fax:
877-234-3048

You will receive your rebate check in about three weeks.

Mail:
Janssen CarePath Savings Program
2250 Perimeter Park Drive, Suite 300
Morrisville, NC 27560

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.

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Pharmacy Benefit Rebate Form

Complete this side of the form only if you are submitting a **pharmacy receipt** for a rebate check **to be sent directly to the patient.**

Receive a Rebate in 4 Easy Steps

1. The patient must be enrolled in the Janssen CarePath Savings Program before receiving a Janssen medication. Patient can enroll by calling 877-CarePath (877-227-3728) or online at **MyJanssenCarePath.com**.
2. Patient must complete the information below and sign the form.
3. Include a copy of the pharmacy receipt. A valid receipt will include patient name, medication (name, J code, and NDC# are all required), date, and amount paid for patient's REMICADE® or Infliximab medication.
   If patient's receipt includes a prescription number and does not include Janssen medication name, also include a copy of patient's prescription label from the medication carton.
4. Submit for a rebate through your online account at **MyJanssenCarePath.com** OR submit this signed form by fax or by mail along with patient's pharmacy receipt and, if required, prescription label from medication carton (see below for details). A completed Rebate Form is not required if submitting rebate request online. Eligible patients will receive a rebate check in about three weeks.

If you are submitting an **Explanation of Benefits (EOB)** and want to receive a rebate check, only complete the Medical Benefit Rebate Form on the previous page.

Complete the information below. *Required

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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, 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. Offer good only in the United States and its territories. Void where prohibited, taxed, or limited by law. REBATE FORM CANNOT BE BOUGHT, TRANSFERRED, OR SOLD. REBATE FORM CANNOT BE COMBINED WITH ANY OTHER OFFER, DISCOUNT, PRESCRIPTION SAVINGS CARD, OR FREE TRIAL. Use of this program is subject to the program requirements, which can be found at Remicade.JanssenCarePathSavings.com.

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*Patient Signature _____ *Date _____

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Fax:
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2250 Perimeter Park Drive, Suite 300
Morrisville, NC 27560

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