Janssen CarePath

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

Remicade® INFLIXIMAB

Medical Benefit Rebate Form

Complete this Medical Benefit Rebate 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. Valid receipt will include patient name, medication (name, J code, or NDC#), 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®. 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.

*Name _____ E-mail _____ *Phone _____

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

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

Out-of-pocket costs paid by this program may not be submitted as a claim for payment to any third-party payer, pharmaceutical patient assistance foundation, or account such as a Flexible Spending Account (FSA), a Health Savings Account (HSA), or a Health Reimbursement Account (HRA).

This program is only available to individuals age 6 or older using commercial or private health insurance for their Janssen medication, including plans available through state and federal healthcare exchanges. This program is not available to individuals who use any state or federal government-funded healthcare program to cover a portion of medication costs, such as Medicare, Medicaid, TRICARE, Department of Defense, or Veterans Administration.

Your eligibility to receive a Savings Program benefit is subject to meeting the program requirements at the time of each Savings Program request. Program terms will expire at the end of each calendar year. Program subject to change or discontinuation without notice, including in specific states. **As a condition of participating in this program, you must ensure that you comply with any co-payment disclosure requirements of your insurance carrier or third-party payer, including disclosing to your insurer the amount of co-payment support you receive from this program. By receiving a Savings Program benefit, you confirm that you have read, understood, and agree to the program requirements shown on this page, and you are giving permission for information related to your Savings Program transactions, including rebates and any funds placed on or balance remaining on the Savings Program card, to be shared with your healthcare provider(s). If you use medical/primary insurance to pay for your medication, you are responsible for submitting a rebate request including an Explanation of Benefits (EOB) to receive payment under the Savings Program. At your direction, your provider may submit the rebate request and EOB on your behalf. Please ensure you and your provider coordinate who will submit the rebate request.** Offer good only in the United States and its territories. Void where prohibited, taxed, or otherwise restricted 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 savings card is subject to the program requirements which can be found on the Janssen CarePath Savings Program Brochure.

By signing, dating, and submitting this form, you confirm that **you already enrolled in the Janssen CarePath Savings Program and activated your savings card before receiving your Janssen medication. Janssen CarePath cannot process this rebate form if you have not completed this process.** In addition, you indicate you read, understand, agree, and meet the terms and conditions on this form, as well as the program requirements which were explained to you when you received the savings card, which may also be found in the Janssen CarePath Savings Program Brochure.

*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 REMICADE® (J1745) 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

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

You will receive your rebate check in about three weeks.

Please read the full Prescribing Information, including Boxed Warnings and Medication Guide for REMICADE®, and discuss any questions you have with your doctor.

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Pharmacy Benefit Rebate Form

Complete this Pharmacy Benefit Rebate 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. Valid receipt will include patient name, medication (name, J code, or NDC#), date, and amount paid for patient's REMICADE® 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

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®. 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.

*Name _____ E-mail _____ *Phone _____

_____ Gender ☐ Male ☐ Female

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

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

Out-of-pocket costs paid by this program may not be submitted as a claim for payment to any third-party payer, pharmaceutical patient assistance foundation, or account such as a Flexible Spending Account (FSA), a Health Savings Account (HSA), or a Health Reimbursement Account (HRA).

This program is only available to individuals age 6 or older using commercial or private health insurance for their Janssen medication, including plans available through state and federal healthcare exchanges. This program is not available to individuals who use any state or federal government-funded healthcare program to cover a portion of medication costs, such as Medicare, Medicaid, TRICARE, Department of Defense, or Veterans Administration.

Your eligibility to receive a Savings Program benefit is subject to meeting the program requirements at the time of each Savings Program request. Program terms will expire at the end of each calendar year. Program subject to change or discontinuation without notice, including in specific states. **As a condition of participating in this program, you must ensure that you comply with any co-payment disclosure requirements of your insurance carrier or third-party payer, including disclosing to your insurer the amount of co-payment support you receive from this program. By receiving a Savings Program benefit, you confirm that you have read, understood, and agree to the program requirements shown on this page, and you are giving permission for information related to your Savings Program transactions, including rebates and any funds placed on or balance remaining on the Savings Program card, to be shared with your healthcare provider(s).** Offer good only in the United States and its territories. Void where prohibited, taxed, or otherwise restricted 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 savings card is subject to the program requirements which can be found on the Janssen CarePath Savings Program Brochure.

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*Patient Signature _____ *Date _____

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2250 Perimeter Park Drive, Suite 300
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