



# Treatment Administration Rebate Program Patient Enrollment Form



\*Required  
 \*SELECT ONE:  Enrollment  Update Information Only  
 Phone: 877-CarePath (877-227-3728) Fax: 844-678-TARP (844-678-8277) [MyJanssenCarePath.com](http://MyJanssenCarePath.com)  
 Monday–Friday, 8:00 AM–8:00 PM ET

PATIENT INFORMATION (*Required)		
*NAME _____ *GENDER <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) _____ E-MAIL _____		
*If you're unavailable when we call, is it ok for us to leave a message including the name of your medication? <input type="checkbox"/> Yes <input type="checkbox"/> No		
*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 treatment <input type="checkbox"/> No, I do not have commercial or private health insurance that I will use for my Janssen treatment	*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 I am responsible for submitting a rebate request including an Explanation of Benefits (EOB) and proof of provider payment for my out-of-pocket treatment administration costs to receive payment under the Treatment Administration Rebate Program. The Program will use the information I submit to determine the amount of treatment administration costs for SIMPONI ARIA® that Janssen Biotech, Inc., will reimburse. That amount will be issued via check payable to me. I further understand that if I do not submit an EOB and proof of provider payment, the Program cannot process my rebate request.

Mail or fax completed enrollment form to: **Mail:** Janssen CarePath Treatment Administration Rebate Program, 2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560 **Fax:** 844-678-TARP (844-678-8277)

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 the next page 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 \_\_\_\_\_

**3 ways for patient to enroll:** Review the program requirements on the next page, then choose the enrollment option you prefer:



**Online at [MyJanssenCarePath.com](http://MyJanssenCarePath.com)**  
 To access the enrollment site, you will need to create an account if you don't already have one.



**Mail or Fax**  
 Complete and sign this form above and mail or fax to:  
 Mail: Janssen CarePath Treatment Administration Rebate Program  
 2250 Perimeter Park Drive, Suite 300  
 Morrisville, NC 27560  
**OR**  
 Fax: 844-678-TARP (844-678-8277)



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

Please read the full [Prescribing Information](#), including Boxed Warnings, and [Medication Guide](#) for SIMPONI ARIA®, and discuss any questions you have with your doctor.

## Patient Eligibility Requirements for Janssen CarePath Treatment Administration Rebate Program

You may be eligible for the Janssen CarePath Treatment Administration Rebate Program if you are age 2 or older and use commercial or private health insurance for treatment with SIMPONI ARIA®.

Janssen CarePath Treatment Administration Rebate Program for SIMPONI ARIA® is based on infusion administration costs only and does not include costs for your medication. To receive a rebate, you must have paid your treatment provider for your out-of-pocket infusion administration costs.

For medication cost support, we offer Janssen CarePath Savings Program. Learn more at [SimponiAria.JanssenCarePathSavings.com](https://SimponiAria.JanssenCarePathSavings.com).

### Other Requirements:

- This program is only for people age 2 or older using commercial or private health insurance for their Janssen treatment. 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 program.
- Program terms will expire at the end of each calendar year. The program may change or end without notice, including in specific states. Not valid for residents of MA, MI, MN, or RI.
- 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. By getting a Treatment Administration Rebate Program benefit, you confirm that you have read, understood, and agree to the program requirements on this page.
- Before you complete enrollment, you will be asked to provide personal information that may include your name, address, phone number, email address, and information related to your healthcare insurance and treatment. This information is needed for Janssen Biotech, Inc., the maker of SIMPONI ARIA®, and our service providers to enroll you in the Janssen CarePath Treatment Administration Rebate Program. We may also use the information you give us to learn more about the people who use SIMPONI ARIA®, and to improve the information we give them. Janssen Biotech, Inc., will not share your information with anyone else except where legally allowed.
- You are responsible for submitting a rebate request with an Explanation of Benefits (EOB) and proof of provider payment to receive payment under the Treatment Administration Rebate Program.
- 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, excluding states noted above. 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).

### NOTE: Your signature on the previous page of this form certifies:

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

Please read the full [Prescribing Information](#), including Boxed Warnings, and [Medication Guide](#) for SIMPONI ARIA®, 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 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 844-678-8277 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](https://www.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 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:

\_\_\_\_\_

