janssen CarePath UPDATE 10.21

Dermatologist Benefits Investigation and Prescription Form

Stelara® (ustekinumab)

Complete and fax this form to 866-769-3903 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

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 2 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

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____ DOB (MM/DD/YYYY) _____

PRIMARY PHONE (Best number to call 8:00 AM to 8:00 PM) _____

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

MEDICAL INSURANCE _____

CARDHOLDER _____

DATE OF BIRTH _____ POLICY# _____ GROUP# _____

PHARMACY INSURANCE _____ PCN# _____

CARDHOLDER _____ DATE OF BIRTH _____

Rx ID _____ Rx BIN# _____ GROUP# _____

SECONDARY INSURANCE _____ CARDHOLDER _____

DATE OF BIRTH _____ POLICY# _____ GROUP# _____

3. CLINICAL INFORMATION (REQUIRED. The information requested is for benefits investigation only. Visit JanssenCarePath.com for ICD-10 codes or consult the ICD-10 code book for additional information)

PRIMARY DIAGNOSIS: **PSORIASIS** ☐ L40.0 (Psoriasis vulgaris) ☐ Other ICD-10 Code _____

PSORIATIC ARTHROPATHY ☐ L40.50 (Arthropathic psoriasis, unspecified) ☐ Other ICD-10 Code _____

SECONDARY DIAGNOSIS: ICD-10 CODE _____

TB TEST DATE _____ DATE OF DIAGNOSIS OR YEARS WITH DISEASE _____

PATIENT WEIGHT _____ lb. _____ kg. % BSA AFFECTED _____

PRIOR THERAPIES (REQUIRED TO COMPLETE PRIOR AUTHORIZATION)

☐ Arava® ☐ Corticosteroids ☐ Cosentyx® ☐ Cyclosporine ☐ Enbrel® ☐ Humira® ☐ Methotrexate ☐ Otezla® ☐ Phototherapy
☐ Skyrizi® ☐ Soriatane® ☐ Taltz® ☐ Tremfya® ☐ Xeljanz® ☐ None ☐ Other _____

4. BENEFITS INVESTIGATION

I would like to request investigation of benefits only for STELARA® at this time ☐ 45 mg single-dose prefilled syringe ☐ 90 mg single-dose prefilled syringe

I would like to request investigation of benefits only for STELARA® 45 mg single-dose vial ☐ 1 vial ☐ 2 vials

SITE OF CARE ☐ Prescribing MD's Office ☐ Non-prescribing MD's Office/Infusion Center ☐ Hospital Outpatient ☐ Other

PHYSICIAN OR INFUSION PROVIDER NAME _____

PRACTICE/FACILITY NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

PHONE _____ FAX _____ CONTACT NAME _____

INSURANCE PROVIDER# _____ TAX ID# _____

Please see full Prescribing Information and Medication Guide for STELARA®. Provide the Medication Guide to your patients and encourage discussion.

5. PRESCRIBER INFORMATION (REQUIRED)

PRESCRIBER NAME (First, Last) _____

PRACTICE NAME _____ OFFICE CONTACT _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

PHONE _____ FAX _____ TAX ID# _____

MEDICAID/MEDICARE PROVIDER# _____ NPI# _____

6. SO SIMPLE TRIAL PROGRAM PRESCRIPTION: OFFER ONLY FOR 45 mg VIAL

Trial Dose for pediatric patients (ages 6-17) weighing less than 60 kg: One 45 mg vial; 0.75 mg/kg SC at Week 0

SHIP STARTER DOSE TO: ☐ Prescriber office ☐ Patient

PRESCRIBER SIGNATURE REQUIRED TO VALIDATE PRESCRIPTION: I certify that therapy with STELARA® is medically necessary for this patient. I will be supervising the patient's treatment accordingly, and I have reviewed the current STELARA® full Prescribing Information. I authorize Janssen CarePath to act on my behalf for the limited purposes of transmitting this prescription to Wegmans Pharmacy. I also indicate that I would like to enroll the patient in the So Simple Trial Program. I understand that the patient will be contacted by Wegmans Pharmacy, on behalf of Janssen CarePath, to initiate therapy and schedule shipping of his/her medication.

PRESCRIBER SIGNATURE (NO STAMPS ALLOWED) _____ DATE _____

7. PRESCRIPTION INFORMATION (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)

Rx DIRECTIONS (select all that apply)

45 mg VIAL STARTER DOSE for plaque psoriasis (ages 6-17) weighing less than 60 kg

If So Simple Trial Program selected above:
☐ 45 mg single-dose vial; 0.75 mg/kg SC at Week 4
☐ 45 mg single-dose vial; 0.75 mg/kg SC at Week 0 and Week 4

PREFILLED SYRINGE STARTER DOSE
☐ Single-dose prefilled syringe; **45 mg SC** at ☐ Week 0 ☐ Week 4
☐ Single-dose prefilled syringe; **90 mg SC** at ☐ Week 0 ☐ Week 4

45 mg VIAL MAINTENANCE THERAPY for plaque psoriasis (ages 6-17) weighing less than 60 kg

☐ 45 mg single-dose vial; 0.75 mg/kg SC every 12 weeks Refills # _____

PREFILLED SYRINGE MAINTENANCE THERAPY
☐ Single-dose prefilled syringe; **45 mg SC** every 12 weeks Refills # _____
☐ Single-dose prefilled syringe; **90 mg SC** every 12 weeks Refills # _____

PRESCRIBER SIGNATURE REQUIRED TO VALIDATE PRESCRIPTION: I certify that therapy with STELARA® is medically necessary for this patient. I will be supervising the patient's treatment accordingly, and I have reviewed the current STELARA® 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 (NO STAMPS ALLOWED) _____ DATE _____

8. JANSSEN LINK PROGRAM

When commercial insurance coverage is delayed >5 business days or denied, Janssen Link offers eligible patients subcutaneous STELARA® **at no cost** until their commercial insurance covers the medication. See program requirements on the next page.
By enrolling patients in Janssen Link, I certify that I agree to the program requirements and will take any necessary action described in the requirements for my patient.

PRESCRIBER SIGNATURE (NO STAMPS ALLOWED) _____ DATE _____

9. PRIOR AUTHORIZATION

Prior Authorization Form Assistance and Status Monitoring: Janssen CarePath assists your office in providing the requirements of the patient's health plan related to prior authorization for treatment with STELARA®. Assistance includes obtaining the health plan-specific prior authorization form, and providing it based upon the patient-specific information provided on this form. The partially completed prior authorization form will be provided to your office for possible completion and submission in the office's sole discretion. Janssen CarePath also actively monitors the status of prior authorization submission to the patient's plan and provides status updates to your office with respect to this patient's prior authorization for treatment with STELARA®.

☐ **I do NOT wish to receive Prior Authorization Form Assistance or Status Monitoring. This opt-out does not apply if you are requesting the patient be enrolled in Janssen Link.**

☐ **Prior Authorization is already on file with the patient's plan for treatment with subcutaneous STELARA®.**

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 Link offers eligible patients subcutaneous STELARA® (ustekinumab) **at no cost** until their commercial insurance covers the medication. See program requirements below.

Janssen Link Program Requirements

To be eligible, patient must have:

1. a subcutaneous STELARA® prescription for an on-label, FDA-approved indication
2. commercial insurance with biologics coverage
3. a delay of more than 5 business days or a denial of treatment from their insurance.

In addition, for patient to be eligible, Prescriber must submit:

4. a program enrollment form*
5. a coverage determination form (ie, prior authorization or prior authorization with exception) to the commercial insurance. If coverage is denied, Prescriber must also submit a Letter of Formulary Exception, Letter of Medical Necessity, or appeal within 90 days of patient becoming eligible for patient to stay in the program.

Patient is not eligible if:

1. patient uses any state or federal government-funded healthcare program to cover medication costs. Examples of these programs are Medicare, Medicaid, TRICARE, Department of Defense, and Veterans Administration
2. prior authorization is denied due to missing information on coverage determination form, use for a non-FDA-approved indication, or invalid clinical rationale.

Patient is eligible until commercial insurance covers the medication. Program requires periodic verification of insurance coverage status to confirm continued eligibility.

Program covers the cost of therapy only—not associated administration cost. Prescriber cannot bill commercial insurance plan for any part of the prescribed subcutaneous treatment. Patient cannot submit the value of the free product as a claim for payment to any health plan. Program good only in the United States and its territories. Void where prohibited, taxed, or limited by law. Program terms may change.

Participating prescribers authorize Janssen CarePath to:

1. conduct a benefits investigation and confirm prior authorization requirements
2. provide prior authorization form assistance and status monitoring, including the exceptions and appeals processes
3. refer eligible patients to Wegmans Specialty Pharmacy for further program support and shipment of medication
4. support the transition of patients to commercial product if the medication is covered
5. check insurance coverage status during the program.

*Janssen CarePath cannot accept any information without an executed Business Associate Agreement and/or Patient Authorization on file. The Patient Authorization can be found on this form, or patient can create an account on **MyJanssenCarePath.com** and electronically sign a patient authorization there.

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 866-769-3903 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:

_____

janssen

  10/21 cp-18950v6