Janssen CarePath

UPDATE 10.16

Benefit Investigation Form

Complete and fax this form to 844-553-2793 or mail to PO Box 220307, Charlotte, NC 28222-0307.
For assistance, call 877-CarePath (877-227-3728), Monday–Friday, 8:00 AM–8:00 PM, ET

DARZALEX® (daratumumab)
injection for intravenous infusion
100 mg/5 mL, 400 mg/20 mL

1. Patient Information (REQUIRED)

NAME (First, MI, Last) _____ SEX ☐ M ☐ F DOB (MM/DD/YYYY) _____

ADDRESS _____ CITY _____

STATE _____ ZIP CODE _____ E-MAIL _____

HOME/CELL PHONE _____ WORK PHONE _____ BEST TIME TO CONTACT _____

CAREGIVER/CONTACT _____
(A caregiver/contact is someone who can be contacted in place of the patient)

HOME/CELL PHONE _____ WORK PHONE _____ BEST TIME TO CONTACT _____

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

PRIMARY INSURANCE _____

CARDHOLDER _____

RELATIONSHIP TO CARDHOLDER _____

EMPLOYER _____ INS. CO. PHONE _____

POLICY# _____ GROUP# _____

SECONDARY INSURANCE _____

CARDHOLDER _____

RELATIONSHIP TO CARDHOLDER _____

EMPLOYER _____ INS. CO. PHONE _____

POLICY# _____ GROUP# _____

☐ **Please investigate out-of-network benefits.**

3. Patient Authorization for Janssen CarePath (To be completed if there is not a valid Business Associate Agreement with the Covered Entity. Patient should read the Patient Authorization on the Patient Copy and sign below)

My signature below certifies that I have read, understand, and agree to the Patient Authorization to release my protected health information to Janssen Biotech, Inc., its parent or affiliate, designee or successor, and specialty pharmacies and other service providers supporting Janssen CarePath as defined on the Patient Copy (collectively, "Janssen Biotech").

☐ **I authorize Janssen CarePath to leave a message, including the prescription name DARZALEX®, if I am unavailable when they call.**

☐ **If I cannot be reached, I authorize Janssen CarePath to contact my caregiver.** ☐ **I prefer and authorize Janssen CarePath to contact my caregiver in place of me.**

PATIENT SIGNATURE _____ DATE _____ PATIENT NAME _____

If patient cannot sign, patient's legally authorized caregiver representative must sign below.

BY _____ NAME OF PERSON LEGALLY AUTHORIZED TO SIGN _____ RELATIONSHIP _____
(Signature of person legally authorized to sign for patient)

4. Prescriber Information (REQUIRED)

PRESCRIBER NAME (First, Last) _____ SPECIALTY _____

PRACTICE/FACILITY NAME _____ OFFICE CONTACT _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

E-MAIL _____ PHONE _____ FAX _____

MEDICAID/MEDICARE PROVIDER# _____ TAX ID# _____

STATE LICENSE# _____ UPIN/NPI# _____

5. Clinical Information (REQUIRED)

DIAGNOSIS CODE _____ DATE OF DIAGNOSIS OR YEARS WITH DISEASE _____

PATIENT WEIGHT _____ lb. _____ kg. PRIOR MEDICATIONS/TREATMENT _____

DOSAGE/FREQUENCY: _____ # OF VIALS TO BE USED PER INFUSION _____ (100 mg) _____ (400 mg)

☐ MONOTHERAPY ☐ COMBINATION THERAPY IF COMBINATION THERAPY, LIST MEDICATIONS _____

HAS THE PATIENT STARTED TREATMENT WITH DARZALEX®? ☐ No ☐ Yes IF YES, START DATE _____

6. Preferred Site of Treatment (REQUIRED)

☐ Prescribing MD's office ☐ Nonprescribing MD's office ☐ Hospital outpatient ☐ Hospital inpatient ☐ Home infusion/Infusion Provider Company ☐ Other _____

If prescribing MD's office, the fields below do not need to be completed if information is the same as in the Prescriber Information section.

PHYSICIAN OR INFUSION PROVIDER NAME _____ PHYSICIAN SPECIALTY _____

PRACTICE/FACILITY NAME _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

PHONE _____ FAX _____ CONTACT NAME _____

INSURANCE PROVIDER# _____ TAX ID# _____

7. Prior Authorization (Please check the appropriate box[es] below to request assistance with prior authorizations)

☐ **Prior Authorization Form Assistance**

By checking this box, I request that Janssen CarePath assist my office in providing the requirements of this patient's health plan related to prior authorization for treatment with DARZALEX®. I understand that assistance includes obtaining the health plan-specific prior authorization form, and providing it based upon the patient-specific information provided on this form. I understand that the partially completed prior authorization form will be provided to my office by Janssen CarePath for possible completion and submission to the health plan.

☐ **Prior Authorization Status Monitoring**

By checking this box, I request that Janssen CarePath actively monitor the status of the prior authorization submission. I request that Janssen CarePath provide status updates to my office with respect to this patient's prior authorization for treatment with DARZALEX®.

Before prescribing DARZALEX®, please click here to read the full Prescribing Information, available at DARZALEX.com.

Print Form

By providing your information and information about your patient on the front of the Benefit Investigation Form, you are requesting the services described on this form. The information you provide will only be used by Janssen Biotech, Inc., our affiliates, and our service providers involved in delivering these services. You may withdraw your request for these services by calling 877-CarePath (877-227-3728). Our Privacy Policy, available at **JanssenCarePath.com/Privacy-Policy**, governs the use of the information you provide. By providing the information and submitting this form, you indicate you read, understand, and agree to these terms.

Patient insurance benefit investigation is provided as a service by The Lash Group, Inc., under contract for Janssen Biotech, Inc. In this regard, The Lash Group, Inc., assists healthcare professionals in the determination of whether treatment could be covered by the applicable third-party payer based on coverage guidelines provided by the payer and patient information provided by the healthcare provider under appropriate authorization following the provider's exclusive determination of medical necessity.

Importantly, insurance verification is the ultimate responsibility of the provider. Third-party reimbursement is affected by many factors. Therefore, The Lash Group, Inc., and Janssen Biotech, Inc., make no representation or guarantee that full or partial insurance reimbursement or any other payment will be available. This information is provided as an information service only. While The Lash Group, Inc., tries to provide correct information, they and Janssen Biotech, Inc., make no representations or warranties, expressed or implied, as to the accuracy of the information. In no event shall The Lash Group, Inc., or Janssen Biotech, Inc., or its employees or agents be liable for any damages resulting from or relating to the services. All providers and other users of this information agree that they accept responsibility for the use of this service.

Janssen Biotech, Inc., assumes no responsibility for, and does not guarantee the quality, scope, or availability of the services including but not limited to reimbursement support services, coordination of prescription fulfillment, patient education, and other support services. Each provider, not Janssen Biotech, Inc., is responsible for the services they provide. These support services have no independent value to providers apart from the product and are included within the cost of the product.

Before prescribing DARZALEX® (daratumumab), please click here to read the full Prescribing Information, available at DARZALEX.com.

janssen
PHARMACEUTICAL COMPANIES
OF Johnson&Johnson

Patient Copy

Provider Instructions

1. **Have the patient read this form and sign the acknowledgement on the front of the Janssen CarePath Benefit Investigation Form relating to the Patient Authorization for DARZALEX® (daratumumab).**
2. **Provide the patient with this sheet and a copy of the front of the Janssen CarePath Benefit Investigation Form, which the patient has signed.**

PATIENT AUTHORIZATION

My signature on the front of the Janssen CarePath Benefit Investigation Form confirms that I authorize each of my physicians, pharmacists, including any specialty pharmacy that receives my prescription for DARZALEX®, and other healthcare providers (together, "Healthcare Providers") and each of my health insurers (together, "Insurers") to disclose my Protected Health Information, including but not limited to medical records, information related to my medical condition and treatment, my health insurance coverage, my name, address, telephone number, Social Security number, insurance plan and/or group numbers (together, "Protected Health Information") to Janssen Biotech, Inc., its affiliated companies, agents and representatives, including providers of alternate sources of funding for prescription drug costs, and other service providers supporting access programs for Healthcare Providers and patients (Janssen CarePath) (together, "Janssen Biotech, Inc.") for the purposes described below.

Specifically, I authorize Janssen Biotech, Inc., to receive, use, and disclose my Protected Health Information in order to (i) enroll me in, and contact me about, Janssen CarePath programs; (ii) provide me with educational materials, information, and services related to DARZALEX®; (iii) verify, investigate, assist with, and coordinate my coverage for DARZALEX® with my Insurers; (iv) coordinate prescription fulfillment; and (v) assist with analyses related to the quality, efficacy, and safety of DARZALEX®, and patient access to and adherence to DARZALEX®. I also understand that pharmacies that ship my medication may be paid to share this information with Janssen CarePath to help provide the offerings requested for me. Furthermore, I understand that my Protected Health Information will not be used or disclosed by Janssen Biotech, Inc., for any other purpose unless permitted by law or unless information that specifically identifies me is removed. I understand that Janssen Biotech, Inc., will make every effort to keep my information private. If my information is accidentally shared, federal privacy laws do not require that the person/party receiving it not disclose the information further. Information disclosed under these circumstances and provided to a third party may no longer be protected by federal privacy laws. For additional information on how Janssen Biotech collects, uses, and discloses personal information, visit **JanssenCarePath.com/Privacy-Policy**.

I understand that I am not required to sign the front of the Janssen CarePath Benefit Investigation Form. My choice about whether to sign will not change the way my Healthcare Providers or Insurers treat me. If I refuse to sign the front of the Janssen CarePath Benefit Investigation Form, or revoke my authorization later, I understand that this means I will not be able to participate or receive assistance from Janssen CarePath.

This authorization will last until I am no longer participating in Janssen CarePath. I understand that I may cancel this authorization at any time by mailing a letter requesting such cancellation to Janssen CarePath, c/o The Lash Group, PO Box 220307, Charlotte, NC 28222-0307. I can also revoke my authorization by informing my Healthcare Providers and Insurers in writing that I do not want them to share any information with Janssen Biotech, Inc., but this will not affect Janssen Biotech, Inc.'s, ability to use and disclose Protected Health Information that it has received prior to its receipt of notification that I wish to discontinue my participation in the program. My authorization will also end if Janssen CarePath is discontinued. Furthermore, I understand that I have the right to see or copy the Protected Health Information my Healthcare Providers or Insurers have given to Janssen Biotech, Inc.

Please click here to read the Important Product Information for DARZALEX®, available at DARZALEX.com, and discuss any questions you have with your doctor.

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