NOTE: PLEASE READ THE PATIENT ELIGIBILITY REQUIREMENTS ON NEXT PAGE PRIOR TO COMPLETING THIS FORM.

Janssen CarePath

UPDATE 9.16

Savings Program
2016/2017 Patient Enrollment Form

Phone: 844-55DARZA (844-553-2792) • Fax: 866-886-9565 • CarePathSavingsProgram.com

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

PATIENT INFORMATION (*Required)

*NAME _____ *GENDER: ☐ MALE ☐ FEMALE *DATE OF BIRTH _____

*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? ☐ YES ☐ NO

REBATE† PAID BY (select one): ☐ Janssen CarePath Savings Program for DARZALEX® Visa® Prepaid‡ Card§ ☐ Mail check to me

*1. Do you currently use private or commercial health insurance to cover at least a portion of your medication costs, including insurance provided through an employer or former employer and insurance you pay for yourself, as well as plans available through state and federal healthcare exchanges?

☐ Yes, I use private or commercial health insurance for my medication

☐ No, I do not use private or commercial health insurance for my medication

*2. Do you confirm that you will NOT seek reimbursement for your medication from any state or federal government-subsidized healthcare program that could cover a portion of your medication costs for DARZALEX® such as those listed below?

- Medicare Part A • Medicare Part B
- Medicare Part C (Medicare Advantage Plan)
- Medicare Part D • Medicaid • TRICARE
- Department of Defense or Veterans Administration

☐ Yes, I confirm that I will NOT seek reimbursement for DARZALEX® from any state or federal government-subsidized healthcare programs

☐ No, I may seek reimbursement for DARZALEX® from a state or federal government-subsidized healthcare program

*3. Do you confirm that you will NOT seek reimbursement for your medication costs for DARZALEX® from any other program, such as those listed below?

- Pharmaceutical patient assistance foundations
- A Flexible Spending Account (FSA)
- A Health Savings Account (HSA)
- A Health Reimbursement Account (HRA)

☐ Yes, I confirm that I will NOT seek reimbursement for DARZALEX® costs from any other programs

☐ No, I may seek reimbursement for DARZALEX® costs from other programs

INSURANCE INFORMATION

PRIMARY INSURANCE NAME _____

CARDHOLDER NAME _____

MY RELATIONSHIP TO CARDHOLDER _____ ☐ SELF

EMPLOYER _____

INSURANCE CO. PHONE # _____

POLICY # _____ GROUP # _____

SECONDARY INSURANCE NAME _____

CARDHOLDER NAME _____

MY RELATIONSHIP TO CARDHOLDER _____ ☐ SELF

EMPLOYER _____

INSURANCE CO. PHONE # _____

POLICY # _____ GROUP # _____

YOUR PRESCRIBER (*Required)

*PRESCRIBER NAME _____ *PRACTICE NAME _____

*ADDRESS _____ *CITY _____ *STATE _____ *ZIP CODE _____

*PHONE # _____ *OFFICE–MAIN FAX # _____

TREATMENT PROVIDER INFORMATION (This section does not need to be completed if information is the same as "YOUR PRESCRIBER")

NAME OF PHYSICIAN _____ OFFICE/HOSPITAL/OTHER NAME _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

PHONE _____ OFFICE–MAIN FAX # _____

☐ Non-Prescribing MD'S Office ☐ Hospital Outpatient ☐ Home Infusion/Infusion Provider Company ☐ Other

By submitting this form, I am requesting to be enrolled in Janssen CarePath Savings Program for DARZALEX® (the "Program"). I understand that my personal information will be used by Janssen Biotech, Inc., including our affiliates and our service providers that work on their behalf (the "Companies"), in connection with the Program, to help me get assistance with the costs of my DARZALEX® therapy, or as otherwise required or allowed under the law. I also understand that the Companies may use my name and contact information for market and outcomes research and to improve the information that the Companies provide to patients who are being treated with DARZALEX®. I understand that the Companies may de-identify my information and use or disclose the de-identified information for any purpose permitted by law. I understand that they will take commercially reasonable efforts to keep my information private.

I understand that the Companies may contact me by telephone, postal mail, or e-mail (if I provide an e-mail address), in connection with my enrollment in the Program. I understand and agree that by enrolling in the Program I may also enroll in the services provided by Janssen CarePath, a Janssen Biotech, Inc., support program for DARZALEX® and other Janssen Biotech, Inc., products. If I choose to participate, these services may include providing educational materials related to my treatment. Janssen CarePath will also contact my provider as necessary to administer these services. I understand that I may pay the full co-pay amount to my healthcare provider when I receive each infusion.

I understand that my provider or I will need to submit my Explanation of Benefits (EOB) or pharmacy receipt to the Program following each infusion. The Program will use the information my provider or I submit to determine the amount of costs for DARZALEX® that Janssen Biotech, Inc., will reimburse. That amount will be credited to my Janssen CarePath Savings Program for DARZALEX® Visa® Prepaid‡ Card§. I further understand that if my provider or I do not submit an EOB or pharmacy receipt, the Program cannot process my rebate† request. I understand that I can use my card for savings if DARZALEX® is obtained from a specialty pharmacy and that if the specialty pharmacy is unable to process my card, I will receive a rebate by submitting my pharmacy receipt. I understand that if a specialty pharmacy provides DARZALEX® to my infusion provider, and can accept the Janssen CarePath Savings Program for DARZALEX® Visa® Prepaid‡ Card§, the rebate† for DARZALEX® will be credited to my Janssen CarePath Savings Program for DARZALEX® Visa® Prepaid‡ Card§ to pay for DARZALEX® at the specialty pharmacy. I also understand that Janssen CarePath and the Program will share Program-related information with my provider. I understand that I can cancel participation in the Program at any time by notifying Janssen CarePath at 844-55DARZA (844-553-2792). Our **Privacy Policy** governs the use of the information you provide. I understand that, if I am enrolled in the Program, Janssen Biotech, Inc., will not be responsible for lost or stolen cards or for any misuse of these cards.

Fax or mail this completed enrollment form to: Fax: 866-886-9565 Mail: Janssen CarePath Savings Program, P.O. Box 4581, Warren, NJ 07059

My signature below certifies that I have completed all of the above sections completely, accurately, and to the best of my knowledge, and that I have read, understand, and agree to the Patient Authorization to release my Protected Health Information as indicated on the next page of this form, including but not limited to spoken or written facts about my health and payment benefits that I may have. It can include copies of records from my healthcare providers or health plans about my health or health care. I understand, accept, and comply with all requirements and restrictions described in the eligibility requirements provided on the next page of this form and I understand that redeeming this rebate* 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 _____ RELATIONSHIP _____

(Signature of person signing for patient)

† This is a reimbursement of out-of-pocket expense and not considered income. ‡ The term "Prepaid" is a requirement of Visa® and does not signify that the card is pre-loaded. § If your infusion provider doesn't accept Visa® debit, you will receive a check.

For assistance or additional information, call Janssen CarePath Support at 844-55DARZA (844-553-2792), Monday–Friday, 8:00 AM–8:00 PM ET.

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

Clear Form Print Form

Patient Authorization (PA)

Patients must read this and sign the acknowledgment on the previous page of this form before they can participate in the Program.

My signature on the previous page of this form confirms that I allow my doctor(s), any other healthcare providers, specialty pharmacy providers, and my health plan or insurers to share medical information relating to my use or potential use of DARZALEX® (daratumumab) with Janssen Biotech, Inc., including our affiliates and our service providers that work on their behalf, in connection with the Program (the "Companies"). The Companies administer Janssen CarePath, and Janssen CarePath Savings Program for DARZALEX® (the "Program") for Janssen Biotech, Inc., maker of DARZALEX®.

This information can include spoken or written facts about my health and payment benefits I may have. It may include copies of records from my healthcare providers or health plans about my health or health care.

The Companies may use and share this information to help find alternate funding sources for DARZALEX®, and perform other related services. The Companies may also share my information with other related parties of this program or as otherwise set forth above.

The Companies will use and share this information to see if I qualify for the Programs and to run the Programs. In addition, the Companies may use and share my information to refer me to other programs, foundations, or alternate sources of funding or coverage that may be available to provide assistance to me with costs of my medication. Program management employees of the Companies may also see my information, but they may use it only in connection with the Program, to help me get assistance with the costs of my medication, or as otherwise required or allowed under the law. I understand that they will make every effort to keep my information private, but if it is accidentally shared with an associated party, federal privacy laws will not protect it.

This Authorization will last until I am no longer participating in the Program. If I change my mind, I can inform my healthcare providers and my insurers in writing that I do not want them to share any information with Janssen CarePath and Janssen CarePath Savings Program (Janssen Biotech, Inc., and other affiliates and companies that work on their behalf, in connection with the Program), but will not change any information shared before I notified them of my desire to discontinue. I know that I have a right to see or copy the information my healthcare providers or insurers have given to the Companies.

I understand that I am not required to sign the previous page of this form. My choice about whether to sign this form will not change the way my healthcare providers or insurers treat me. If I refuse to sign the previous page of this form, I know that this means I will not be able to receive assistance from the Program.

Patient Eligibility Requirements for Janssen CarePath Savings Program

Benefits are available to individuals who currently use private or commercial health insurance to cover a portion of the medication costs for DARZALEX®.

Other Requirements:

- This offer may not be combined with any other coupon, discount, prescription savings card, free trial, or other offer.
- This program is only available to individuals using private or commercial health insurance to cover a portion of their medication costs, including plans available through state and federal healthcare exchanges. This program is not available to individuals who use any state or federal government-subsidized healthcare program to cover a portion of medication costs, such as Medicare, Medicaid, TRICARE, Department of Defense, or Veterans Administration. Patients confirm that they will not seek reimbursement from any of these programs or from pharmaceutical patient assistance foundations and accounts such as a Flexible Spending Account (FSA), Health Savings Account (HSA), or Health Reimbursement Account (HRA).
- The selling, purchasing, trading, or counterfeiting of this card is prohibited.
- Offer good only in the United States and Puerto Rico. Janssen Biotech, Inc., reserves the right to rescind, revoke, or amend this offer without notice at any time. Void where prohibited, taxed, or otherwise restricted by law.
- Offer for new enrollment expires December 31, 2017. For Massachusetts residents only, this offer is subject to change per state legislation.
- Before you activate your card, it is important that you understand that you will be asked to provide personal information that may include your name, address, phone number, email address, and information related to your insurance and treatment. This information is necessary to permit Janssen Biotech, Inc., the maker of DARZALEX® and companies that work with Janssen Biotech, Inc., including our affiliates and our service providers, to fulfill your request to enroll in the Janssen CarePath Savings Program. We may also use the information you give us to learn more about the people who use DARZALEX®, and to improve the information we provide to people who are being treated with DARZALEX®. Janssen Biotech, Inc., will not share your information with anyone else except as required by law.
- 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.
- This program is not retroactive.

3 ways to enroll: Review the eligibility requirements above, then choose the enrollment option you prefer:

Online:
CarePathSavingsProgram.com

Phone:
844-55DARZA (844-553-2792)

Form:
Complete and sign the previous page of this form, and fax or mail to:
Fax: 866-886-9565 **OR** Mail: Janssen CarePath Savings Program
P.O. Box 4581
Warren, NJ 07059

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.
- That you have read, understand, and agree to the Patient Authorization to release your Protected Health Information as indicated above, including but not limited to spoken or written facts about your health and payment benefits you may have. It can include copies of records from your healthcare providers or health plans about your health or health care.

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

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