Janssen CarePath

UPDATE 11.17

Benefit Investigation Form

Complete and fax this form to 866-836-0567 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

EDURANT® (rilpivirine) tablets
PREZISTA® (darunavir) tablets
INTELENCE® (etravirine) tablets
PREZCOBIX® (darunavir 800 mg/cobicistat 150 mg) tablets

1. Patient Information

PATIENT NAME _____ DOB (MM/DD/YYYY) _____ ☐ MALE ☐ FEMALE

NAME OF GUARDIAN (IF APPLICABLE) _____

PATIENT ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

PRIMARY PHONE _____ SECONDARY PHONE _____

2. Insurance Information

PRIMARY INSURANCE _____

PRIMARY INSURANCE PHONE _____

CARDHOLDER _____

CARDHOLDER DOB (MM/DD/YYYY) _____

RELATIONSHIP TO CARDHOLDER _____

POLICY# _____ GROUP# _____

PROVIDER ID # FOR INSURANCE _____

SECONDARY INSURANCE _____

SECONDARY INSURANCE PHONE _____

CARDHOLDER _____

CARDHOLDER DOB (MM/DD/YYYY) _____

RELATIONSHIP TO CARDHOLDER _____

POLICY# _____ GROUP# _____

PROVIDER ID # FOR INSURANCE _____

RX CARD PATIENT ID _____

3. Physician Information

NAME OF FACILITY _____ FACILITY TAX ID # _____

PROVIDER TRANSACTION ACCESS # (PTAN) _____ PHYSICIAN MEDICAID PROVIDER ID # _____

NAME OF PHYSICIAN _____ SPECIALTY _____

ADDRESS _____ CITY _____ STATE ___ ZIP CODE _____

PHONE _____ FAX _____

OFFICE CONTACT _____ OFFICE CONTACT PHONE _____

TAX ID # _____ NPI # _____

4. Drug Therapy

VERIFY BENEFITS FOR: ☐ EDURANT® ☐ INTELENCE® ☐ PREZISTA® ☐ PREZCOBIX® DOSING _____ MG

DIAGNOSIS CODE: _____

ADDITIONAL INFORMATION REGARDING TREATMENT (IF APPLICABLE TO BENEFITS VERIFICATION)

_____

5. Prior Authorization: If you would like Janssen CarePath to provide support for the prior authorization process, please check the appropriate box(es).

☐ **Prior Authorization Form Preparation** 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 the product noted in the Drug Therapy portion of this form. 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 the product noted in the Drug Therapy portion of this form.

Please see full Prescribing Information for EDURANT®, INTELENCE®, PREZISTA®, and PREZCOBIX®.

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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 Johnson & Johnson Health Care Systems 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 benefits investigation is provided by contracted service providers for Janssen CarePath, which is operated by Johnson & Johnson Health Care Systems Inc. on behalf of Janssen Pharmaceuticals, Inc., Janssen Biotech, Inc., and Janssen Products, LP. In this regard, Janssen CarePath assists healthcare providers 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. This reimbursement support service has no independent value to providers apart from the product and is included within the cost of the product. While Janssen CarePath attempts to provide correct information, they make no representations or warranties, expressed or implied, as to the accuracy of the information. In no event shall Janssen CarePath, Janssen, 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. Importantly, insurance verification is the ultimate responsibility of the provider.

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Please see full Prescribing Information for EDURANT® (rilpivirine), INTELENCE® (etravirine), PREZISTA® (darunavir), and PREZCOBIX® (darunavir 800 mg/cobicistat 150 mg).

janssen
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Janssen CarePath Patient Authorization

- **Patients should read the Patient Authorization and sign electronically or download, print, and sign.**
  - **Completed form may be uploaded to Patient Account or Provider Portal, faxed to Janssen CarePath at 866-836-0567 or mailed to address below.**
- **Patients can access a copy of completed form in their Janssen CarePath Account – My Profile.**

My signature on this Patient Authorization Form confirms that I authorize each of my physicians, pharmacists, including any specialty pharmacy which receives my prescription for a Janssen medication 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 information related to my medical condition and treatment, my health insurance coverage, my name, address, telephone number, insurance plan and or group numbers (together, "Protected Health Information") to Johnson & Johnson Health Care Systems Inc., its affiliated companies, agents and representatives (together, "Janssen"), including providers of alternate sources of funding for prescription drug costs, and other approved service providers authorized to manage, administer, and/or support Janssen CarePath programs, Janssen CarePath Account for Patients, and Provider Portal for their Healthcare Providers for the purposes described below.

Specifically, I authorize Janssen to receive, use, and disclose my Protected Health Information in order to (i) enroll me in, determine my eligibility for, and contact me about, Janssen medication support programs; (ii) provide me with educational materials, information, and services related to my Janssen medication; (iii) verify, investigate, assist with, and coordinate my coverage for my Janssen medication with my Insurers; (iv) coordinate prescription fulfillment; (v) assist with analyses related to the quality, efficacy, and safety of my Janssen medication, and patient access to and adherence to my Janssen medication; (vi) to share and provide access to, information generated by Janssen CarePath that may be useful for my care, and; (vii) to improve, develop, and evaluate Janssen CarePath, its offerings, and materials. 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 for any other purpose without my prior authorization unless permitted by law or unless information that specifically identifies me is removed. I understand that Janssen will make every effort to keep my information private. Further, I understand that if my information is accidentally shared, federal privacy laws do not require that the person/party receiving it not disclose the information further and that such information provided to a third party may no longer be protected by federal privacy laws.

I understand that I am not required to sign this Patient Authorization 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 Patient Authorization 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, or accessing my Janssen CarePath Account. I understand that I may cancel or revoke this Authorization at any time by mailing a letter requesting such cancellation to Janssen CarePath, 2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560 or by informing my Healthcare Providers and Insurers in writing that I do not want them to share any information with Janssen. I further understand that cancellation or revocation will not affect Janssen's ability to use and disclose Protected Health Information that it has received prior to its receipt of my cancellation and revocation of participation in the program. My authorization will also end if Janssen CarePath support programs or the Janssen CarePath Account 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.

Patient name: _____ Date of Birth (mm/dd/yyyy): _____

Patient address: _____

City: _____ State: _____ ZIP Code: _____

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 CarePath
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Morrisville, NC 27560
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