

## 1. PATIENT INFORMATION (REQUIRED)

NAME (First, MI, Last) \_\_\_\_\_ SEX  M  F  
 DOB (MM/DD/YYYY) \_\_\_\_\_ ADDRESS \_\_\_\_\_  
 CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_ E-MAIL \_\_\_\_\_  
 CELL PHONE \_\_\_\_\_ HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
 PREFERRED NUMBER TO CALL  Cell  Home  Work BEST TIME TO CONTACT  Morning  Afternoon  Evening

## 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# \_\_\_\_\_  
**PRESCRIPTION DRUG INSURER** \_\_\_\_\_ CARD/BIN# \_\_\_\_\_ PHONE \_\_\_\_\_

Is patient a dependent of the insured (child <18 yrs; student >18 yrs)? Check if yes.

PLEASE INVESTIGATE OUT-OF-NETWORK BENEFITS FOR REMICADE®

**NOTE:** For SIMPONI®, pharmacy benefit will be investigated. If patient does not have a pharmacy benefit, medical benefits will be investigated.

## 3. PATIENT AUTHORIZATION (To be completed only when [1] there is not a valid Business Associate Agreement with the Covered Entity, or [2] the Covered Entity has signed a Limitation of Services request. 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 the provider of the support services as defined on the Patient Copy (collectively, "Janssen Biotech").

**PATIENT SIGNATURE** \_\_\_\_\_ DATE \_\_\_\_\_ PATIENT NAME \_\_\_\_\_  
 If patient cannot sign, patient's legally authorized representative must sign below.

PATIENT NAME \_\_\_\_\_ BY \_\_\_\_\_  
 (Signature of person legally authorized to sign for patient/relationship)

## 4. PRESCRIBER INFORMATION (REQUIRED)

PRESCRIBER NAME (First, Last) \_\_\_\_\_  
 SPECIALTY \_\_\_\_\_  
 PRACTICE NAME \_\_\_\_\_ OFFICE CONTACT \_\_\_\_\_  
 ADDRESS \_\_\_\_\_  
 CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_  
 E-MAIL \_\_\_\_\_ PHONE \_\_\_\_\_ FAX \_\_\_\_\_  
 MEDICAID/MEDICARE PROVIDER# \_\_\_\_\_ TAX ID# \_\_\_\_\_  
 STATE LICENSE# \_\_\_\_\_ UPIN/NPI# \_\_\_\_\_  
**Are you the prescribing specialist?** (Required)  YES  NO: IF NO, REFERRING SPECIALIST \_\_\_\_\_  
 REFERRING PHYSICIAN SPECIALTY \_\_\_\_\_

## 5. REMICADE® PREFERRED SITE OF INFUSION (REQUIRED)

(Fields below do not need to be completed if information is the same as in the Prescriber Information section)

Prescribing MD's office  Non-prescribing MD's office  Hospital outpatient  Home infusion/Infusion Provider Company  Other  
 PHYSICIAN OR INFUSION PROVIDER NAME \_\_\_\_\_  
 PRACTICE/FACILITY NAME \_\_\_\_\_  
 ADDRESS \_\_\_\_\_  
 CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_  
 PHONE \_\_\_\_\_ FAX \_\_\_\_\_ CONTACT NAME \_\_\_\_\_  
 INSURANCE PROVIDER# \_\_\_\_\_ TAX ID# \_\_\_\_\_

## 6. CLINICAL INFORMATION (REQUIRED. Visit JanssenCarePath.com for ICD-10 codes or consult the ICD-10 code book for additional information)

### ■ REMICADE®—DIAGNOSIS: Crohn's Disease, Fistula (Secondary to Crohn's Disease), Ulcerative Colitis

DIAGNOSIS CODE \_\_\_\_\_ INDICATION \_\_\_\_\_  
 DOSAGE/FREQUENCY \_\_\_\_\_ NUMBER OF PRIOR REMICADE® INFUSIONS  unknown  0  3  4+  
 # OF VIALS TO BE USED \_\_\_\_\_ ANTICIPATED # OF INFUSIONS \_\_\_\_\_

### ■ SIMPONI®—DIAGNOSIS: Ulcerative Colitis

DIAGNOSIS CODE \_\_\_\_\_ INDICATION \_\_\_\_\_

### ■ ADDITIONAL CLINICAL INFORMATION

DATE OF DIAGNOSIS OR YEARS WITH DISEASE \_\_\_\_\_ PATIENT WEIGHT \_\_\_\_\_ lb. \_\_\_\_\_ kg.  
 PREVIOUS TB TEST (DATE) \_\_\_\_\_ HEPATITIS B VIRUS TEST (DATE) \_\_\_\_\_ SCHEDULED DATE OF INFUSION \_\_\_\_\_

## 7. PRIOR MEDICATIONS (REQUIRED. Specify—P=Prior, C=Current, F=Failure)

5-ASA  Azathioprine  Cimzia\*  Cyclosporine  Methotrexate  
 6-MP  Azulfidine\*  Corticosteroids  Humira\*  Other \_\_\_\_\_

## 8. PRESCRIPTION INFORMATION: Rx: SIMPONI® (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)

### DIRECTIONS: STARTER DOSES

200 mg at Week 0; 2 single-use autoinjectors, 100 mg/1.0 mL SC  100 mg at Week 2; 1 single-use autoinjector, 100 mg/1.0 mL SC  
 200 mg at Week 0; 2 single-use prefilled syringes, 100 mg/1.0 mL SC  100 mg at Week 2; 1 single-use prefilled syringe, 100 mg/1.0 mL SC

### MAINTENANCE THERAPY

1 single-use autoinjector, 100 mg/1.0 mL SC every 4 weeks  1 single-use prefilled syringe, 100 mg/1.0 mL SC every 4 weeks Refills # \_\_\_\_\_  
 OTHER \_\_\_\_\_ Refills # \_\_\_\_\_

■ **PRESCRIBER SIGNATURE (NO STAMPS ALLOWED) REQUIRED TO VALIDATE PRESCRIPTION:** I certify that therapy with SIMPONI® is medically necessary for this patient. I will be supervising the patient's treatment accordingly, and I have reviewed the current SIMPONI® 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** (Dispense as Written) \_\_\_\_\_ DATE \_\_\_\_\_

SUPERVISING PHYSICIAN SIGNATURE (if applicable) \_\_\_\_\_ DATE \_\_\_\_\_

SUPERVISING PHYSICIAN NAME \_\_\_\_\_

## 9. SHIPPING INFORMATION FOR SIMPONI® (REQUIRED to complete benefit investigation even if not prescribing. NOTE: Shipments cannot be sent to P.O. Boxes)

SHIP TO:  PROVIDER OFFICE—Initial injection only  
 PATIENT'S HOME—I have instructed the patient in proper injection technique for SIMPONI® and the patient will self-administer  OTHER

NAME (if different than above) \_\_\_\_\_  
 ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_  
 ZIP CODE \_\_\_\_\_ PHONE \_\_\_\_\_ FAX \_\_\_\_\_

## 10. PRIOR AUTHORIZATION SERVICES (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 REMICADE® or SIMPONI®. 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 specified medication.

## 11. PREFERRED SPECIALTY PHARMACY (Provider to check one below)

As the treating physician, I have discussed preference for a Specialty Pharmacy (SP) with this patient. This patient prefers use of the SP indicated below. I authorize Janssen Biotech, Inc., and its representatives to fax this prescription to: **1.** The SP designated as checked below, provided it is approved by this patient's plan. **2.** If the SP designated is not a plan-approved SP, then to a SP approved by this patient's plan. **3.** If there is no preferred SP indicated, then to any SP approved by this patient's plan.

Accredo  Amber  BioPlus  BriovaRx  CVS Caremark  Cigna  Diplomat  Humana  
 Modern TLC  Prime Therapeutics SP  Senderra  Walgreens  Other \_\_\_\_\_

By providing your information and information about your patient on the front of the Benefit Investigation and Prescription 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](https://www.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, 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 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, 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 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, 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.

**Please see Important Safety Information and full Prescribing Information, including Boxed Warnings, and Medication Guide for REMICADE® and SIMPONI®, available at [JanssenCarePath.com](https://www.janssencarepath.com).**

## Patient Copy

### Provider Instructions

1. Have the patient read this form and sign the acknowledgements on the front of the Benefit Investigation and Prescription Form relating to the Patient Authorization.
2. Provide the patient with this sheet and a copy of the front of the Benefit Investigation and Prescription Form, which they have signed.

## PATIENT AUTHORIZATION

My signature on the front of the Benefit Investigation and Prescription Form confirms that I authorize each of my physicians, pharmacists, including any specialty pharmacy that receives my prescription for REMICADE® (infliximab) or SIMPONI® (golimumab) 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 (Support Services) (together, “Janssen Biotech”) for the purposes described below.

Specifically, I authorize Janssen Biotech to receive, use, and disclose my Protected Health Information in order to (i) enroll me in, and contact me about, REMICADE® or SIMPONI® support services; (ii) provide me with educational materials, information, and services related to REMICADE® or SIMPONI®; (iii) verify, investigate, assist with, and coordinate my coverage for REMICADE® or SIMPONI® with my Insurers; (iv) coordinate prescription fulfillment; and (v) assist with analyses related to the quality, efficacy, and safety of REMICADE® or SIMPONI®, and patient access to and adherence to REMICADE® or SIMPONI®. I also understand that pharmacies that ship my medication may be paid to share this information with REMICADE® or SIMPONI® support services 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 for any other purpose unless permitted by law or unless information that specifically identifies me is removed. I understand that Janssen Biotech 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](https://www.janssencarepath.com/Privacy-Policy).

I understand that I am not required to sign the front of the Benefit Investigation and Prescription 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 Benefit Investigation and Prescription Form, or revoke my authorization later, I understand that this means I will not be able to participate or receive assistance from the support services for REMICADE® or SIMPONI® support programs.

This authorization will last until I am no longer participating in the support services. 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, Inc., P.O. Box 218, Monroeville, PA 15146-2230. 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, but this will not affect Janssen Biotech’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 the support services for REMICADE® or SIMPONI® are 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.

**You are encouraged to report negative side effects of prescription drugs to the FDA. Visit [fda.gov/medwatch](https://www.fda.gov/medwatch), or call 800-FDA-1088.**

**Please see Important Safety Information and full Prescribing Information, including Boxed Warnings, and Medication Guide for REMICADE® and SIMPONI®, available at [JanssenCarePath.com](https://www.janssencarepath.com).**

