janssen CarePath

UPDATE 9.16

Benefit Investigation Form

Please complete and fax this form to 855-227-3721 or mail to P.O. Box 247, Monroeville, PA 15146.
For assistance, call 877-CarePath (877-227-3728), Monday–Friday, 8:00 AM–8:00 PM ET.

Invokana® canagliflozin tablets | Invokamet® canagliflozin/metformin HCl tablets | Invokamet® XR ONCE-DAILY canagliflozin/metformin HCl extended-release tablets | Xarelto® rivaroxaban tablets

1. PATIENT INFORMATION (Required)

NAME (First, MI, Last)_____

ADDRESS_____

CITY_____ STATE_____ ZIP CODE_____

E-MAIL_____

HOME PHONE_____ CELL PHONE_____

WORK PHONE_____ SEX ☐ M ☐ F DOB (MM/DD/YYYY)_____

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_____

(Please include alpha prefix and suffix with policy and group# when applicable)

3. PATIENT AUTHORIZATION FOR JANSSEN CAREPATH SERVICES (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 Pharmaceuticals, Inc., and companies working on their behalf, including vendors, other affiliates, and other service providers supporting Janssen CarePath as defined on the Patient Copy (collectively, "Janssen Pharmaceuticals, Inc.").

I would be interested in receiving additional information about enrolling in Janssen CarePath, a support program for patients and caregivers. ☐ Yes ☐ No

I authorize Janssen CarePath to leave a message, including the prescription name INVOKANA®, INVOKAMET®, INVOKAMET® XR, or XARELTO®, if I am unavailable when they call. ☐ Yes ☐ No

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.

NAME OF PERSON LEGALLY AUTHORIZED TO SIGN_____

RELATIONSHIP_____ PHONE NUMBER_____

4. 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 the medication specified above. I understand that assistance includes obtaining the health plan-specific prior authorization form, and completing 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.

5. PRESCRIBER INFORMATION (Required. Verification of Benefits will be faxed to this Prescriber)

PRACTICE NAME_____ OFFICE CONTACT_____

PRESCRIBER NAME (First, Last)_____ SPECIALTY_____

ADDRESS_____

CITY_____ STATE_____ ZIP CODE_____

E-MAIL_____

PHONE_____ FAX_____

MEDICAID/MEDICARE PROVIDER#_____ TAX ID#_____

STATE LICENSE#_____ UPIN/NPI#_____

6. CLINICAL INFORMATION FOR INVOKANA®

(Required. Visit JanssenCarePath.com for ICD-10 codes or consult the ICD-10 code book for additional information)

DIAGNOSIS CODE:_____ INDICATION:_____

DATE OF DIAGNOSIS OR YEARS WITH DISEASE_____

DOSAGE: ☐ 100-mg canagliflozin once daily ☐ 300-mg canagliflozin once daily

☐ COMMENT/OTHER_____

7. CLINICAL INFORMATION FOR INVOKAMET®

(Required. Visit JanssenCarePath.com for ICD-10 codes or consult the ICD-10 code book for additional information)

DIAGNOSIS CODE:_____ INDICATION:_____

DATE OF DIAGNOSIS OR YEARS WITH DISEASE_____

DOSAGE: ☐ 50-mg canagliflozin/500-mg metformin HCl twice daily

☐ 150-mg canagliflozin/500-mg metformin HCl twice daily

☐ 50-mg canagliflozin/1000-mg metformin HCl twice daily

☐ 150-mg canagliflozin/1000-mg metformin HCl twice daily

☐ COMMENT/OTHER_____

8. CLINICAL INFORMATION FOR INVOKAMET® XR

(Required. Visit JanssenCarePath.com for ICD-10 codes or consult the ICD-10 code book for additional information)

DIAGNOSIS CODE:_____ INDICATION:_____

DATE OF DIAGNOSIS OR YEARS WITH DISEASE_____

DOSAGE: ☐ 50-mg canagliflozin/500-mg metformin HCL extended-release once daily

☐ 150-mg canagliflozin/500-mg metformin HCL extended-release once daily

☐ 50-mg canagliflozin/1000-mg metformin HCL extended-release once daily

☐ 150-mg canagliflozin/1000-mg metformin HCL extended-release once daily

☐ COMMENT/OTHER_____

9. CLINICAL INFORMATION FOR XARELTO®

(Required. Visit JanssenCarePath.com for ICD-10 codes or consult the ICD-10 code book for additional information)

DIAGNOSIS CODE:_____ INDICATION:_____

DATE OF PROCEDURE_____

DOSAGE: ☐ 15-mg ☐ 20-mg ☐ 30-day Starter Pack*

*XARELTO Starter Pack™ includes 15-mg twice daily for first 21 days; 20-mg once daily for Days 22-30.

I would be interested in having Janssen CarePath contact my patient for a dose change reminder ☐ Yes ☐ No

☐ COMMENT/OTHER_____

Clear Form 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 Pharmaceuticals, 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 support services administrator under contract for Janssen Pharmaceuticals, Inc. In this regard, the support services administrator 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 support services administrator, and Janssen Pharmaceuticals, 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 support services administrator tries to provide correct information, it and Janssen Pharmaceuticals, Inc., make no representations or warranties, expressed or implied, as to the accuracy of the information. In no event shall the support services administrator or Janssen Pharmaceuticals, 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 Pharmaceuticals, 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, patient education, and other support services. Each provider, not Janssen Pharmaceuticals, 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.

Please see the full Prescribing Information for INVOKANA®, the full Prescribing Information, including Boxed WARNINGS for INVOKAMET®, INVOKAMET® XR, and XARELTO®, and the Medication Guide for INVOKANA®, INVOKAMET®, INVOKAMET® XR, and XARELTO®, available at JanssenCarePath.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 Benefit Investigation Form for INVOKANA® (canagliflozin), INVOKAMET® (canagliflozin/metformin HCl), INVOKAMET® XR (canagliflozin/metformin HCl extended-release), or XARELTO® (rivaroxaban).**
2. **Provide the patient with this sheet and a copy of the front of the Benefit Investigation Form for INVOKANA®, INVOKAMET®, INVOKAMET® XR, or XARELTO®, which they have signed.**

PATIENT AUTHORIZATION

My signature on the front of the Benefit Investigation Form for INVOKANA®, INVOKAMET®, INVOKAMET® XR, or XARELTO® confirms that I authorize each of my physicians, pharmacists, 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 Pharmaceuticals, 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 Pharmaceuticals, Inc.") for the purposes described below.

Specifically, I authorize Janssen Pharmaceuticals, Inc., to receive, use, and disclose my Protected Health Information in order to (i) enroll me in, and contact me and/or the person legally authorized to sign on my behalf, about Janssen CarePath programs; (ii) provide me and/or the person legally authorized to sign on my behalf with educational materials, information, and services related to INVOKANA®, INVOKAMET®, INVOKAMET® XR, or XARELTO®; (iii) verify, investigate, assist with, and coordinate my coverage for INVOKANA®, INVOKAMET®, INVOKAMET® XR, or XARELTO® with my Insurers; (iv) coordinate prescription fulfillment; and (v) assist with analyses related to the quality, efficacy, and safety of INVOKANA®, INVOKAMET®, INVOKAMET® XR, or XARELTO®, and patient access to and adherence to INVOKANA®, INVOKAMET®, INVOKAMET® XR, or XARELTO®. 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 Pharmaceuticals, Inc., for any other purpose unless permitted by law or unless information that specifically identifies me is removed. I understand that Janssen Pharmaceuticals, 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 Pharmaceuticals, Inc., collects, uses, and discloses personal information, visit **JanssenCarePath.com/Privacy-Policy**.

I understand that I am not required to sign the front of the Benefit Investigation Form for INVOKANA®, INVOKAMET®, INVOKAMET® XR, or XARELTO®. 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 Form for INVOKANA®, INVOKAMET®, INVOKAMET® XR, or XARELTO®, or revoke my authorization later, I understand that this means I will not be able to participate in or receive assistance from Janssen CarePath.

I understand that I may cancel (revoke) this Authorization at any time by mailing a letter to Janssen CarePath, c/o The Lash Group, Inc., P.O. Box 247, Monroeville, PA, 15146. 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 Pharmaceuticals, Inc., but this will not affect the ability of Janssen Pharmaceuticals, Inc., 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 Pharmaceuticals, Inc.

Please see the full Prescribing Information for INVOKANA®, the full Prescribing Information, including Boxed WARNINGS for INVOKAMET®, INVOKAMET® XR, and XARELTO®, and the Medication Guide for INVOKANA®, INVOKAMET®, INVOKAMET® XR, and XARELTO®, available at JanssenCarePath.com and discuss any questions you have with your doctor.

For assistance or additional information, call 877-CarePath (877-227-3728), Monday–Friday, 8:00 AM–8:00 PM ET.

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