Janssen CarePath

UPDATE 8.16

Benefit Investigation and Enrollment Form

Complete and fax this form to 866-489-5955 or mail to P.O. Box 220829, Charlotte, NC 28222-0829.
For assistance or additional information, call 877-CarePath (877-227-3728), Monday–Friday, 8:00 AM–8:00 PM, ET

Simponi ARIA® golimumab for infusion

Remicade® INFLIXIMAB

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.

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, Inc.").

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

☐ Acetaminophen, ibuprofen, naproxen sodium, or other over-the-counter pain relievers _____ ☐ Humira* _____ ☐ Methotrexate _____

☐ 5-ASA _____ ☐ 6-MP _____ ☐ Calcipotriene _____ ☐ Cyclophosphamide _____ ☐ Hydroxychloroquine _____ ☐ Orencia* _____

☐ Actemra* _____ ☐ Celebrex* _____ ☐ Cyclosporine _____ ☐ Indocin* _____ ☐ Penicillamine _____

☐ Azathioprine _____ ☐ Cimzia* _____ ☐ Enbrel* _____ ☐ Kineret* _____ ☐ Rituxan* _____

☐ Azulfidine* _____ ☐ Corticosteroids _____ ☐ Gold Compounds _____ ☐ Leflunomide _____ ☐ Other _____

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

■ SIMPONI ARIA®

DIAGNOSIS CODE _____ INDICATION _____

■ REMICADE®

PRIMARY DIAGNOSIS

DIAGNOSIS CODE _____ INDICATION _____

SECONDARY DIAGNOSIS

DIAGNOSIS CODE _____ INDICATION _____

DIAGNOSIS CODE _____ INDICATION _____

■ Therapy with SIMPONI ARIA®

DOSAGE/FREQUENCY: 2 mg/kg at Week 0, Week 4, and q8 weeks thereafter. # OF VIALS TO BE USED _____

ANTICIPATED # OF INFUSIONS _____ NUMBER OF PRIOR SIMPONI ARIA® INFUSIONS ☐ unknown ☐ 0 ☐ 1-3 ☐ 4+

■ Therapy with REMICADE®

DOSAGE/FREQUENCY: _____ # OF VIALS TO BE USED _____

ANTICIPATED # OF INFUSIONS _____ NUMBER OF PRIOR REMICADE® INFUSIONS ☐ unknown ☐ 0 ☐ 1-3 ☐ 4+

■ 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. 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 # _____

8. 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 the medication specified. 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 medication specified.

Please see full Prescribing Information including Indications, Boxed Warnings, and Medication Guide for REMICADE® and SIMPONI ARIA®, also available at JanssenCarePath.com.

By providing your information and information about your patient on the front of the Benefit Investigation and Enrollment 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.

Please see full Prescribing Information including Indications, Boxed Warnings, and Medication Guide for REMICADE® and SIMPONI ARIA®, also available at JanssenCarePath.com.

janssen
PHARMACEUTICAL COMPANIES
OF Johnson&Johnson

Patient Copy

Provider Instructions

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

PATIENT AUTHORIZATION

My signature on the front of the Benefit Investigation and Enrollment Form confirms that I authorize each of my physicians, pharmacists, including any specialty pharmacy which receives my prescription for SIMPONI ARIA® (golimumab) or REMICADE® (infliximab) for infusion 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, 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, SIMPONI ARIA® or REMICADE® support services; (ii) provide me with educational materials, information, and services related to SIMPONI ARIA® or REMICADE®; (iii) verify, investigate, assist with, and coordinate my coverage for SIMPONI ARIA® or REMICADE® with my Insurers; (iv) coordinate prescription fulfillment; and (v) assist with analyses related to the quality, efficacy, and safety of SIMPONI ARIA® or REMICADE®, and patient access to and adherence to SIMPONI ARIA® or REMICADE®. 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, 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 and Enrollment 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 Enrollment 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 SIMPONI ARIA® or REMICADE® 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, 3735 Glen Lake Drive, Suite 300, Charlotte, NC 28208. 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.', 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 SIMPONI ARIA® or REMICADE® 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, Inc.

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit fda.gov/medwatch, or call 800-FDA-1088.

Please see full Prescribing Information, including Indications, Boxed Warnings, and Medication Guide for SIMPONI ARIA®, also available at SimponiAria.com, and REMICADE®, also available at Remicade.com, and discuss any questions with your doctor.

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