Janssen CarePath

## Initiating benefits investigation is easy

### For prescribers

- ☐ Complete the required Prescriber Information and Clinical Information sections on pages 1-3
- ☐ Complete the optional Treatment Location Information section on page 2 (DARZALEX®, PROCRIT®, SYLVANT®, and YONDELIS® only)
- ☐ Complete the optional Prescription Information and the Preferred Pharmacy Information sections on page 3 (ERLEADA™ and ZYTIGA® only)
- ☐ If needed, check the appropriate boxes in the Prior Authorization section on page 1

### For your patients/caregivers

- ☐ Complete or have your patient complete the Patient Information and Insurance Information sections on page 4
- ☐ If you do not have a signed Business Associate Agreement (BAA) on file with Janssen CarePath, have your patient read, sign, and date the Patient Authorization on page 5
  - Give your patient a copy of the signed Patient Authorization form and keep the original for your records

**Fax the completed and signed Benefits Investigation Form to Janssen CarePath at 855-998-4422**

## Here's what happens next

### For prescribers

**Janssen CarePath will:**

- Medical Benefit: Confirm receipt of requests within 2 hours and verify benefits within 1 to 2 business days
- Pharmacy Benefit: Verify benefits within 4-6 business hours
- Provide you with a verification of benefits and call your patient to review the benefits

### For your patients/caregivers

**Janssen CarePath will:**

- Call your patient to review the benefits and provide you with a verification of benefits
- Inform your patient about cost support options and offer your patient care coordination support services with the infusion provider or specialty pharmacy

DARZALEX® (daratumumab) injection for intravenous infusion 100 mg/5 mL, 400 mg/20 mL | PROCRIT® EPOETIN ALFA | sylvant® siltuximab | Yondelis® (trabectedin) — Medical Benefit

Erleada® (apalutamide) tablets | Zytiga® abiraterone acetate — Pharmacy Benefit

**Need help?** Call **877-CarePath** (877-227-3728)
Monday–Friday, 8:00 AM–8:00 PM ET

Please see full Prescribing Information for DARZALEX®, SYLVANT®, YONDELIS®, ERLEADA™, and ZYTIGA®, also available at JanssenCarePath.com.

Please see full Prescribing Information, including Boxed Warnings and Medication Guide for PROCRIT®, also available at JanssenCarePath.com. Provide the Medication Guide to your patients and encourage discussion.

YONDELIS® (trabectedin) is under license from Pharma Mar, S.A.

Janssen CarePath UPDATE 2.18

# Benefits Investigation Form

## Prescriber Information—to be completed by Physician (Required)

Prescriber Name (First, Last) _____ Specialty _____

Practice Name _____ Office Contact _____

Address _____

City _____ State _____ ZIP _____

Email _____ Phone _____ Fax _____

Medicaid/Medicare Provider # _____ Tax ID # _____

State License # _____ UPIN/NPI # _____

## Prior Authorization—to be completed by Physician (Optional)

### Please check the appropriate box 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 the 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 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 above.

By providing your information and information about your patient on the Benefits 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 and other Janssen CarePath program offerings are provided by third-party service providers for Janssen CarePath, under contract with Johnson & Johnson Health Care Systems Inc. on behalf of Janssen Pharmaceuticals, Inc., Janssen Biotech, Inc., and Janssen Products, LP (Janssen). Janssen CarePath is not available to patients participating in the Patient Assistance Program offered by Johnson & Johnson Patient Assistance Foundation. The availability of information and assistance may vary based on the Janssen medication, geography and other program differences. 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 information and assistance are made available as a convenience to patients, and there is no requirement that patients or HCPs use any Janssen product in exchange for this information or assistance. Janssen assumes no responsibility for and does not guarantee the quality, scope, or availability of the information and assistance provided. The third-party service providers, not Janssen, are responsible for the information and assistance provided under this program. Each HCP and patient is responsible for verifying or confirming any information provided. All claims and other submissions to payers should be in compliance with all applicable requirements.

Janssen CarePath

# Benefits Investigation Form

## Clinical Information: IV Only—to be completed by Physician (Required)

### Medication

☐ DARZALEX® (daratumumab) ☐ YONDELIS® (trabectedin) ☐ PROCRIT® (epoetin alfa) ☐ SYLVANT® (siltuximab)

### Treatment Information

Primary Diagnosis Code _____ Primary Diagnosis Indication _____

Approximate Date of Patient's Diagnosis (mm/dd/yyyy) _____

Secondary Diagnosis (Optional) _____

Dosage Form and Strength _____ No. of Vials _____

Administration _____

Patient Weight _____ lbs _____ kg

Has the patient started therapy with the medication specified above? ☐ Yes ☐ No

If yes, what date did the patient start therapy? (mm/dd/yyyy) _____

Additional information regarding treatment (if applicable to benefits verification)

_____

### DARZALEX® only:

☐ Monotherapy
☐ Combination Therapy

If Combination, list medications:

_____
_____
_____

Prior Medications/Treatments:

_____
_____
_____

### PROCRIT® only:

Initial HCT _____ %

Initial Hb _____ g/dL

For cancer patients, is the patient on chemotherapy? ☐ Yes ☐ No

Is the patient a nephrology patient? ☐ Yes ☐ No

If nephrology patient, what is the patient's:

Serum creatinine _____ mg/dL

Creatinine clearance _____ mL/min

Is the patient taking PROCRIT® preoperatively? ☐ Yes ☐ No

If yes, surgery type _____

### YONDELIS® only:

Patient Height _____ ft _____ in

Patient BSA _____

Has the patient taken a prior chemotherapy? ☐ Yes ☐ No

If yes, what prior chemotherapy has the patient taken?

☐ Anthracycline
☐ Ifosfamide
☐ Other _____

☐ Please investigate benefits for YONDELIS® infused through an ambulatory pump through a central venous catheter

## Treatment Location Information: IV Only—to be completed by Physician (Optional)

### Treatment Location Type

☐ Prescribing MD's Office ☐ Non-prescribing MD's Office ☐ Home Infusion/Infusion Provider Company
☐ Hospital Outpatient ☐ Hospital Inpatient ☐ Other _____

### Provider Information

If prescribing MD's office, the fields below do not need to be completed if information is the same as the Prescriber Information section.

Provider Name (First, Last) _____ Physician Specialty _____

Practice Name _____

Address _____

City _____ State _____ ZIP _____

Site Phone _____ Site Fax _____

Insurance Provider # _____ Tax ID # _____

**Please see full Prescribing Information for DARZALEX®, SYLVANT®, and YONDELIS®, also available at JanssenCarePath.com.**

**Please see full Prescribing Information, including Boxed Warnings and Medication Guide for PROCRIT®, also available at JanssenCarePath.com. Provide the Medication Guide to your patients and encourage discussion.**

Janssen CarePath

# Benefits Investigation Form

## Clinical Information: Orals Only—to be completed by Physician (Required)

### Medication

☐ ERLEADA™ (apalutamide) ☐ ZYTIGA® (abiraterone acetate) ☐ Other _____

### Treatment Information

Primary Diagnosis Code: C61 Primary Diagnosis Indication: Malignant neoplasm of prostate

Approximate Date of Patient's Diagnosis (mm/dd/yyyy) _____

## Prescription Information: to be completed by Physician (Optional)

If requesting benefits investigation only, do not complete this section. The prescription is only valid if received by fax. **SPECIAL NOTE:** New York Prescribers, please submit prescription on an original NY State prescription blank. For all other states, if not faxed, prescription must be submitted on state-specific blank, if applicable for your state.

**Rx ERLEADA™** ☐ 60 mg Tablet

**Directions:** Take 240 mg once daily with or without food Quantity _____ Refills # _____

**Rx ZYTIGA®** ☐ 250 mg Tablet ☐ 500 mg Film-Coated Tablet

**Directions:** Take _____ mg PO _____ daily on an empty stomach Quantity _____ Refills # _____

**Initial Dosing:** For patients with baseline moderate hepatic impairment (Child-Pugh Class B), reduce the ZYTIGA® starting dose to 250 mg once daily (see Dose Medication Guidelines for more information). Do not use ZYTIGA® in women who are or may become pregnant and patients with baseline severe hepatic impairment (Child-Pugh Class C). Refer to the ZYTIGA® full PRESCRIBING INFORMATION, including the following sections: INDICATIONS AND USAGE, CONTRAINDICATIONS, DOSAGE AND ADMINISTRATION, WARNING AND PRECAUTIONS, ADVERSE REACTIONS, DRUG INTERACTIONS, and USE IN SPECIFIC POPULATIONS prior to initiating treatment.

**Rx Prednisone** ☐ 5 mg tablet

**Directions:** Take _____ Quantity _____ Refills # _____

**Prednisone is required to be taken with ZYTIGA®; however, it is optional to include on this Benefits Investigation Form. You may provide a prescription direct to the patient to be filled at a pharmacy that can fill the script. NOTE: Janssen CarePath will not investigate benefits for prednisone. Please refer to full Prescribing Information for complete information prior to initiating treatment.**

Prescriber Name (if different from page 1) _____

Address _____

City _____ State _____ ZIP _____

Phone _____ Fax _____

**PRESCRIBER SIGNATURE (NO STAMPS) REQUIRED. I certify that therapy with the Janssen medication indicated above is medically necessary for this patient. I will be supervising the patient's treatment accordingly, and I have reviewed the current Prescribing Information for the Janssen medication indicated above. 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 _____

**Prescriber Signature >>** (Substitutions allowed) _____ Date _____

**Supervising Physician Signature >>** (if applicable) _____ Date _____

Supervising Physician Name _____

## Preferred Pharmacy: Orals Only—to be completed by Physician (Optional)

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 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.

Preferred Specialty Pharmacy _____ ☐ Self-dispensing Pharmacy

**Please see full Prescribing Information for ERLEADA™ and ZYTIGA®, also available at JanssenCarePath.com.**

Janssen CarePath

# Benefits Investigation Form

## Patient Information (Required)

Name (First, MI, Last) _____ Language ☐ English ☐ Spanish

☐ Male ☐ Female Date of Birth (mm/dd/yyyy) _____

Address _____

City _____ State _____ ZIP _____

Primary Email _____ Secondary Email (Optional) _____

Primary Phone _____ Secondary Phone (Optional) _____ Best Time to Contact _____

Caregiver/Contact _____
(A caregiver/contact is someone who can be contacted in place of the patient)

Home/Cell Phone _____ Work Phone _____ Best Time to Contact _____

☐ I authorize Janssen CarePath to leave a message, including the name of the Janssen medication indicated on this form, if I am unavailable when they call.

☐ If I cannot be reached, I authorize Janssen CarePath to contact my caregiver.

☐ I prefer and authorize Janssen CarePath to contact my caregiver in place of me.

## Insurance Information (Required)

**Please provide insurance information for all health insurance coverage you may have.**

### Primary Medical Insurance

Primary Insurance Carrier _____ Phone _____

Cardholder Name (First, MI, Last) _____ Relationship to Cardholder _____

Cardholder Employer _____ Policy # _____ Group # _____

### Secondary Medical Insurance (Optional)

Secondary Insurance Carrier _____ Phone _____

Cardholder Name (First, MI, Last) _____ Relationship to Cardholder _____

Cardholder Employer _____ Policy # _____ Group # _____

### Prescription Drug Insurance

Prescription Drug Insurer _____ Card BIN # _____ Phone _____

Cardholder Name (First, MI, Last) _____ Relationship to Cardholder _____

Cardholder Employer _____ Policy # _____ Group # _____

☐ **Please investigate out-of-network benefits.** ☐ **Please see attached insurance card.**

Janssen CarePath

# 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 855-998-4422 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 _____

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**
**2250 Perimeter Park Drive, Suite 300**
**Morrisville, NC 27560**
**Fax 855-998-4422**

janssen