PATIENT AUTHORIZATION FORM FOR REMICADE® (infliximab), SIMPONI® (golimumab), SIMPONI ARIA® (golimumab), STELARA® (ustekinumab), and TREMFYA™ (guselkumab)

Provider Instructions:

- **To be completed only when (1) there is not a valid Business Associate Agreement, or (2) the Covered Entity has signed a Limitation of Services request.**
- **Patients should read the Patient Authorization and sign below.**
- **A copy of this form must be provided to the patient.**

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 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 (Janssen CarePath) (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, 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; and (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. 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 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.

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. 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, P.O. Box 220829, Charlotte, NC 28222-0829. 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 Janssen CarePath Support programs 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.

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

Patient address: ____

City: ______________________________ State: ______ ZIP Code: ______________

Patient sign here: ______________________________ Date: ______________

If 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:

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Fax completed form to 866-489-5955 or mail to
Janssen CarePath, P.O. Box 220829, Charlotte, NC 28222-0829

Please read the full Prescribing Information, including Boxed Warnings, for SIMPONI ARIA®, REMICADE® and SIMPONI®, the full Prescribing Information for STELARA® or TREMFYA™, and the Medication Guide for SIMPONI ARIA®, REMICADE®, SIMPONI®, STELARA® or TREMFYA™.

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