janssen CarePath UPDATE 8.16

Benefit Investigation Form

Please complete this form and provide to Janssen CarePath by calling 877-CarePath (877-227-3728) Monday–Friday between the hours of 8:00 AM–8:00 PM ET or by faxing it to 866-489-5955.

Remicade® INFLIXIMAB

1. PRESCRIBER INFORMATION (REQUIRED)

Prescriber name _____

Practice name _____

Address _____

City _____ State _____ ZIP _____

Phone _____ Fax _____

Office contact name _____ Ext. _____

Provider specialty _____

Provider # (as it pertains to commercial insurance below) _____

Medicaid/Medicare provider # _____

Tax ID # _____ UPIN/NPI # _____

Are you the prescribing specialist? (REQUIRED)

☐ Yes ☐ No (If No, complete section 1B)

1B. Name of Referring Specialist _____

Referring physician specialty _____

2. PATIENT INFORMATION (REQUIRED)

Name (First, MI, Last) _____

Address _____

City _____ State _____ ZIP _____

Home phone _____

DOB (MM/DD/YYYY) _____ Gender ☐ Male ☐ Female

3. INSURANCE INFORMATION (REQUIRED)

(Fax copy of enlarged patient insurance card(s) or provide the information below)

Insurance company #1 _____

Primary insured name _____

Employer _____

Insurance company phone _____

Policy # _____ Group # _____

(Please include alpha prefix and suffix where applicable)

Insurance company #2 _____

Primary insured name _____

Employer _____

Insurance company phone _____

Policy # _____ Group # _____

(Please include alpha prefix and suffix where applicable)

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

☐ **Please investigate out-of-network benefits**

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

Primary Diagnosis:

Diagnosis Code _____ Indication _____

Secondary Diagnosis:

Diagnosis Code _____ Indication _____

Comment/Other _____

Date of diagnosis or years with disease _____

4. THERAPY WITH REMICADE®

Previous TB test (date) _____ Hepatitis B Virus test (date) _____

Dosage/frequency _____

Patient weight _____ lb. _____ kg. # of vials to be used _____

Anticipated # of infusions _____

Number of prior REMICADE® infusions ☐ unknown ☐ 0 ☐ 1-3 ☐ 4+

Scheduled date of infusion _____

5. MEDICATIONS (Specify current dosage and time on therapy)

Therapy	Dosage	P = Prior C = Current F = Failure	Months <3	Months 3–6	Months >6
☐ 5-ASA			☐	☐	☐
☐ Sulfasalazine			☐	☐	☐
☐ Azathioprine			☐	☐	☐
☐ 6-MP			☐	☐	☐
☐ Prednisone			☐	☐	☐
☐ Methotrexate			☐	☐	☐
☐ Cyclosporine			☐	☐	☐
☐ Retinoids			☐	☐	☐
☐ Gold compounds			☐	☐	☐
☐ Hydroxychloroquine			☐	☐	☐
☐ Cyclophosphamide			☐	☐	☐
☐ Penicillamine			☐	☐	☐
☐ Leflunomide			☐	☐	☐
☐ Etanercept			☐	☐	☐
☐ Anakinra			☐	☐	☐
☐ Adalimumab			☐	☐	☐
☐ Abatacept			☐	☐	☐
☐ Rituximab			☐	☐	☐
☐ Phototherapy			☐	☐	☐
☐ Other: _____			☐	☐	☐

6. PRIOR AUTHORIZATION

If you would like Janssen CarePath to provide support for the prior authorization process, please check the appropriate box(es):

☐ **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®. 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 REMICADE®.

7. PREFERRED SITE OF INFUSION (REQUIRED)

☐ Prescribing MD's office ☐ Non-prescribing MD's office ☐ Other

☐ Hospital outpatient ☐ Home infusion/Infusion Provider Company

(Fields below do not need to be completed if information is the same as in section 1)

Physician or infusion provider name _____

Physician specialty _____

Practice/facility name _____

Address _____

City _____ State _____ ZIP _____

Phone _____ Fax _____

Contact name _____

Insurance provider # _____ Tax ID # _____

PATIENT AUTHORIZATION

To comply with the HIPAA Privacy Rule, Janssen CarePath must have a signed patient authorization and/or business associate agreement on file.

Please click here to read the Indications, Important Safety Information, and full Prescribing Information, including Boxed Warnings and Medication Guide for REMICADE®, also available at JanssenCarePath.com.

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 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, 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 click here to read the Indications, Important Safety Information, and full Prescribing Information, including Boxed Warnings and Medication Guide for REMICADE® (infliximab), also available at JanssenCarePath.com.

Janssen Biotech, Inc.

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