Janssen CarePath

Savings Program
877-CarePath (877-227-3728)
Monday–Friday, 8:00 AM–8:00 PM ET

Remicade® INFLIXIMAB

EOB Clarification Form

Use this form when the Explanation of Benefits (EOB) statement for the below patient does not indicate that he/she received REMICADE® (ie: REMICADE® OR J1745).

Instructions for Completing and Submitting the EOB Clarification Form

1. Complete the information requested below.
2. Sign and fax the form to 877-234-3048.

Please submit this completed form to ensure your patient receives his or her rebate promptly.

Provider Name _____

Infusion Location _____ Date _____

In order to determine the patient's rebate, please provide information for the patient's treatment with REMICADE® and the Date of Treatment, as requested below.

The information you provide will be used by Janssen Biotech, Inc., the maker of REMICADE®, our affiliates, and our service providers, to determine if your patient is eligible to receive benefits related to their participation in the Janssen CarePath Savings Program for REMICADE®. The benefits may include processing of a rebate request. If your patient wants to stop receiving this information or service they may withdraw from the program by calling 877-CarePath (877-227-3728). Our **Privacy Policy** governs the use of the information you provide. By completing and submitting this form, you indicate you read, understand, and agree, to these terms.

Patient Name _____ Date of Birth (MM/DD/YYYY) _____

Date of Treatment _____

By signing below, you are confirming that this patient received treatment with REMICADE® on the date listed above.

Signature _____ Print Name _____

If you have any questions about Janssen CarePath Savings Program, please call 877-CarePath (877-227-3728), Monday–Friday, 8 AM–8 PM ET.

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

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Clear Form Print Form