NOTE: PLEASE READ THE PATIENT ELIGIBILITY REQUIREMENTS ON THE NEXT PAGE PRIOR TO COMPLETING THIS FORM.

Janssen CarePath

Savings Program
2019/2020 Patient Enrollment Form

Remicade® INFLIXIMAB

*Required

*SELECT ONE: ☐ Enrollment ☐ Update Information Only

Phone: 877-CarePath (877-227-3728) Fax: 877-234-3048 MyJanssenCarePath.com

PATIENT INFORMATION (*Required)

*Do you have a REMICADE® Mastercard®? ☐ Yes ☐ No If yes, provide 11-digit ID number at bottom of card: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

*NAME _____ *GENDER ☐ Male ☐ Female *DATE OF BIRTH (MM/DD/YYYY) _____

*ADDRESS _____ *CITY _____ *STATE _____ *ZIP CODE _____

*PRIMARY PHONE (Best number to call 8:00 AM–8:00 PM ET, weekdays) _____ E-MAIL _____

*If you're unavailable when we call, is it ok for us to leave a message including the name of your medication? ☐ Yes ☐ No

Your rebate will be applied to a REMICADE® Mastercard to pay for your medication at your treatment provider or pharmacy. This card is not a credit card. There is no charge for this card. If your treatment provider or pharmacy DOES NOT ACCEPT the REMICADE® Mastercard, please call 877-CarePath (877-227-3728), Monday through Friday, 8:00 AM–8:00 PM ET, to discuss alternate payment options.

*1. Do you currently have commercial or private health insurance that you will use for your Janssen medication, including commercial insurance provided through an employer or former employer, provided to you as a federal or state employee, and insurance you pay for yourself, as well as plans available through state and federal healthcare exchanges?

☐ Yes, I have commercial or private health insurance that I will use for my Janssen medication

☐ No, I do not have commercial or private health insurance that I will use for my Janssen medication

*2. Do you confirm that you will NOT seek reimbursement from any state or federal government-subsidized healthcare program to cover a portion of the Janssen medication costs such as Medicare Parts A, B, C (also known as Medicare Advantage Plan), D, and Medicare Supplement, Medicaid, TRICARE, Department of Defense, or Veterans Administration?

☐ Yes, I confirm that I will NOT seek reimbursement from any state or federal government-subsidized program for my Janssen medication

☐ No, I may seek reimbursement from a state or federal government-subsidized healthcare program for my Janssen medication

*3. Do you confirm that you will not submit out-of-pocket costs paid by this program as a claim for payment to any third-party payer, pharmaceutical patient assistance foundation, or account such as a Flexible Spending Account (FSA), a Health Savings Account (HSA), or a Health Reimbursement Account (HRA)?

☐ Yes, I confirm that I will NOT submit out-of-pocket costs paid by this program as a claim for payment to any third-party payer, pharmaceutical patient assistance foundation, or account

☐ No, I may submit out-of-pocket costs paid by this program as a claim for payment to a third-party payer, pharmaceutical patient assistance foundation, or account

By submitting this form, I am requesting to be enrolled in Janssen CarePath Savings Program for REMICADE® (the "Program"). I understand that my personal information will be used by Janssen Biotech, Inc., the maker of REMICADE®, including our affiliates and our service providers that work on their behalf (the "Companies"), in connection with the Program, to help me get assistance with the costs of REMICADE®, or as otherwise required or allowed under the law. I also understand that the Companies may use my name and contact information for market and outcomes research and to improve the information that the Companies provide to patients who are being treated with REMICADE®.

I understand that the Companies may de-identify my information and use or disclose the de-identified information for any purpose permitted by law. I understand that they will take commercially reasonable efforts to keep my information private. I understand that the Companies may contact me by telephone, postal mail, or e-mail (if I provide an e-mail), in connection with my enrollment in the Program. I understand and agree that by enrolling in the Program I may also enroll to receive the information and resources provided by Janssen CarePath, a support program for REMICADE® and other Janssen Biotech, Inc., products. If I choose to participate, the information and resources may include providing educational materials related to my treatment. Janssen CarePath will also contact my provider as necessary to administer support that I request. I understand that if I am using medical/primary insurance to pay for my Janssen medication, I am responsible for submitting a rebate request including an Explanation of Benefits (EOB) to receive payment following each treatment. At my direction, my provider may submit the rebate request on my behalf. I will coordinate with my provider who will submit the rebate request. The Program will use the information my provider or I submit to determine the amount of costs for REMICADE® that Janssen Biotech, Inc., will reimburse. That amount will be credited to my REMICADE® Mastercard. I further understand that if my provider or I do not submit an EOB or pharmacy receipt, the Program cannot process my rebate request. I understand that I can use my Savings Program card for instant savings if REMICADE® is obtained from a pharmacy and that if the pharmacy is unable to process my Savings Program card, I will receive a rebate by submitting my pharmacy receipt. I understand that if a pharmacy provides REMICADE® to my treatment provider, and can accept REMICADE® Mastercard, the rebate for REMICADE® will be credited to my REMICADE® Mastercard to pay for REMICADE® at the pharmacy. By participating in the Savings Program, I am giving permission for information related to my Savings Program transactions, including rebates and any funds placed on or balance remaining on the Savings Program card, to be shared with my healthcare provider(s).

I understand that I can cancel participation in the Program at any time by notifying Janssen CarePath at 877-CarePath (877-227-3728). Our **Privacy Policy** governs the use of the information you provide. I understand that, if I am enrolled in the Program, Janssen Biotech, Inc., will not be responsible for lost or stolen cards or for any misuse of these cards.

Fax or mail completed enrollment form to: Fax: 877-234-3048 Mail: Janssen CarePath Savings Program, 2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560

My signature below certifies that I have completed all of the above sections completely, accurately, and to the best of my knowledge, and that I have read, understand, and agree to the Patient Authorization to release my Protected Health Information as indicated on the next page of this form, including but not limited to spoken or written facts about my health and payment benefits that I may have. It can include copies of records from my healthcare providers or health plans about my health or health care. I understand, accept, and comply with all requirements and restrictions described in the eligibility requirements provided on the next page and I understand that redeeming this benefit is consistent with the requirements of my health plan.

PATIENT SIGNATURE _____ DATE _____ PATIENT NAME _____
If the patient cannot sign, patient's personal representative must sign below (Please print)

PATIENT NAME _____ BY _____
(Signature of person signing for patient)

RELATIONSHIP TO PATIENT AND AUTHORITY TO MAKE MEDICAL DECISIONS FOR PATIENT _____

YOUR PRESCRIBER (*Required)

*PRESCRIBER NAME _____ *PRACTICE NAME _____

*ADDRESS _____ *CITY _____ *STATE _____ *ZIP CODE _____

*PHONE # _____ *OFFICE–MAIN FAX # _____

TREATMENT PROVIDER INFORMATION (This section does not need to be completed if information is the same as "YOUR PRESCRIBER")

NAME OF PHYSICIAN _____ OFFICE/HOSPITAL/OTHER NAME _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

PHONE # _____ OFFICE–MAIN FAX # _____

☐ Non-prescribing MD's Office ☐ Hospital Outpatient ☐ Home Treatment/Treatment Provider Company ☐ Other

Please read the full **Prescribing Information**, including Boxed Warnings, and **Medication Guide** for REMICADE®, and discuss any questions you have with your doctor.

For assistance or additional information, call 877-CarePath (877-227-3728), Monday–Friday, 8:00 AM–8:00 PM ET

Patient Authorization

Patients must read this and sign the acknowledgment on the previous page before they can participate in the Program.

My signature on the previous page of this form confirms that I authorize each of my physicians, pharmacists, including any specialty pharmacy that 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 form on the previous page. My choice about whether to sign will not change the way my Healthcare Providers or Insurers treat me. If I refuse to sign on the previous page of this 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 Eligibility Requirements for Janssen CarePath Savings Program

Benefits are available to individuals who currently use commercial or private health insurance to cover a portion of the medication costs for REMICADE® (infliximab). There is no income requirement. Janssen CarePath Savings Program for REMICADE® is based on medication costs only and does not include costs to give you your infusions.

Other Requirements:

- **This program is only available to individuals age 6 or older using commercial or private health insurance for their Janssen medication, including plans available through state and federal healthcare exchanges.** This program is not available to individuals who use any state or federal government-funded healthcare program to cover a portion of medication costs, such as Medicare, Medicaid, TRICARE, Department of Defense, or Veterans Administration.
- Out-of-pocket costs paid by this program may not be submitted as a claim for payment to any third-party payer, pharmaceutical patient assistance foundation, or account such as a Flexible Spending Account (FSA), a Health Savings Account (HSA), or a Health Reimbursement Account (HRA).
- Program terms will expire at the end of each calendar year. Before the calendar year ends, you will receive information and eligibility requirements for continued participation. Program subject to change or discontinuation without notice, including in specific states.
- As a condition of participating in this program, you must ensure that you comply with any co-payment disclosure requirements of your insurance carrier or third-party payer, including disclosing to your insurer the amount of co-payment support you receive from this program. By participating in the program, you are giving permission for information related to your Savings Program transactions, including rebates and any funds placed on or balance remaining on the Savings Program card, to be shared with your healthcare provider(s).
- Before you activate your card, it is important that you understand that you will be asked to provide personal information that may include your name, address, phone number, email address, and information related to your prescription medication insurance and treatment. This information is necessary to permit Janssen Biotech, Inc., the maker of REMICADE®, and companies that work with Janssen Biotech, Inc., including our affiliates and our service providers, to fulfill your request to enroll in the Janssen CarePath Savings Program. We may also use the information you give us to learn more about the people who use REMICADE®, and to improve the information we provide to people who are being treated with REMICADE®. Janssen Biotech, Inc., will not share your information with anyone else except as required by law.
- If you use medical/primary insurance to pay for your medication, you are responsible for submitting a rebate request including an Explanation of Benefits (EOB) to receive payment under the Savings Program. At your direction, your provider may submit the rebate request and EOB on your behalf. Please ensure you and your provider coordinate who will submit the rebate request.
- This program offer may not be combined with any other coupon, discount, prescription savings card, free trial, or other offer for reduced medication cost. The selling, purchasing, trading, or counterfeiting of this card is prohibited. Offer good only in the United States and its territories. Void where prohibited, taxed, or otherwise restricted by law.

Janssen CarePath is in no way an extension of medical treatment provided by healthcare professionals to individual patients. You may discontinue your participation at any time by calling 877-CarePath (877-227-3728).

3 ways to enroll: Review the program requirements above, then choose the enrollment option you prefer:

Online:
MyJanssenCarePath.com

Phone:
877-CarePath (877-227-3728)

Form:
Complete and sign the previous page of this form, and fax or mail to:
Fax:877-234-3048 **OR** Mail: Janssen CarePath Savings Program
2250 Perimeter Park Drive, Suite 300
Morrisville, NC 27560

NOTE: Your signature on the previous page of this form certifies:

- That you understand, accept, and comply with all requirements described above, and that your participation in the Program is consistent with the requirements of your health plan.
- That you have read, understand, and agree to the Patient Authorization to release your Protected Health Information as indicated above, including but not limited to spoken or written facts about your health and payment benefits you may have. It can include copies of records from your healthcare providers or health plans about your health or health care.

Please read the full Prescribing Information, including Boxed Warnings, and Medication Guide for REMICADE®, and discuss any questions you have with your doctor.

janssen