Janssen CarePath UPDATE 6.16

Physician Plan of Treatment for Infusion Referral

Complete and fax this form to 866-489-5955 or mail to P.O. Box 220829, Charlotte, NC 28222-0829.
For assistance or additional information, call 877-CarePath (877-227-3728), Monday–Friday, 8:00AM–8:00PM, ET

Remicade® INFLIXIMAB

1. Patient Information (REQUIRED)

By providing your information and information about your patient, 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** 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.

Name____________________ Gender ☐M ☐F DOB (mm/dd/yyyy)____________________
Address____________________ City____________________
State____________________ ZIP Code____________________ E-mail____________________
Cell Phone____________________ Home Phone____________________ Work Phone____________________
Preferred number to call: ☐Cell ☐Home ☐Work Best time to contact: ☐Morning ☐Afternoon ☐Evening

2. Insurance Information (REQUIRED. Include alpha prefix and suffix with policy and group# when applicable OR PROVIDE A COPY OF INSURANCE CARDS)

Primary Insurance____________________
Policy #____________________
Group #____________________
Policy Holder's Name____________________
Insurance Co. Phone____________________

Secondary Insurance____________________
Policy #____________________
Group #____________________
Policy Holder's Name____________________
Insurance Co. Phone____________________

Prescription Drug Insurer____________________ Card/BIN#____________________ Phone____________________
☐**Check if no insurance.** ☐Is patient a dependent of the insured (child <18 yrs; student >18 yrs)? Check if yes.
☐**Please investigate out-of-network benefits.**

3. Prescriber Information (REQUIRED)

Prescribing Physician____________________ Practice Name____________________
Address____________________ City____________________
State____________________ ZIP Code____________________ E-mail____________________
Phone____________________ Fax____________________ Office Contact____________________
Provider # (as it pertains to commercial insurance below)____________________ Medicaid/Medicare provider #____________________
Tax ID #____________________ UPIN/NPI #____________________

4. Clinical Information (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____________________
Diagnosis Code____________________ Indication____________________
Comment/Other____________________ **Date of diagnosis or years with disease**____________________

5. Referral to Specific Provider (REQUIRED)

☐Referral Source Unknown ☐ Home Infusion/Infusion Provider Company____________________
☐Referral to____________________ Phone____________________
Address____________________
City____________________ State__________ ZIP Code____________________

6. Prior Authorization (Please check the appropriate box[es] 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 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. Therapy with REMICADE®

Previous TB Test (Date)____________________ Hepatitis B Virus Test (Date)____________________ Dosage/Frequency____________________
Patient Weight____________________ lb.____________________kg. Number of Vials to Be Used____________________
Anticipated Number of Infusions____________________ Number of Prior Infusions with REMICADE®: ☐0 ☐1–3 ☐4+
☐Please supply treatment notes to prescribing practice contact at fax number listed above. ☐It is not necessary to send treatment notes.

PRESCRIBER SIGNATURE REQUIRED TO VALIDATE PRESCRIPTION: I certify that therapy with REMICADE® is medically necessary for this patient. I will be supervising the patient's treatment accordingly and I have reviewed the current REMICADE® Prescribing Information. 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____________________

To comply with the HIPAA Privacy Rule, Janssen CarePath must have a signed patient authorization and/or Business Associate Agreement on file.

Before prescribing REMICADE®, please see full Prescribing Information, including Boxed Warnings and Medication Guide for REMICADE®, available at REMICADE.com. Provide the Medication Guide to your patients and encourage discussion.

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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, Inc., 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, Inc., 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, Inc., 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.

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