Janssen CarePath

UPDATE 8.16

Prescription Information and Enrollment Form

Complete and fax this form to 855-224-5072 or mail to PO Box 218, Monroeville, PA 15146-2230.
For assistance or additional information, call 877-CarePath (877-227-3728), Monday–Friday, 8:00 AM–8:00 PM, ET

Simponi® golimumab

1. PATIENT INFORMATION (REQUIRED)

NAME (First, MI, Last) _____ SEX ☐ 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 _____ CARDHOLDER _____

RELATIONSHIP TO CARDHOLDER _____ EMPLOYER _____ INS. CO. PHONE _____

POLICY# _____ GROUP# _____

SECONDARY INSURANCE _____ CARDHOLDER _____

RELATIONSHIP TO CARDHOLDER _____ EMPLOYER _____ INS. CO. PHONE _____

POLICY# _____ GROUP# _____

PRESCRIPTION DRUG INSURER _____ CARD/BIN# _____ PHONE _____

NOTE: Pharmacy benefit will be investigated. If patient does not have a pharmacy benefit, medical benefits will be investigated.

3. PATIENT AUTHORIZATION (To be completed only when [1] there is not a valid Business Associate Agreement with the Covered Entity, or [2] the Covered Entity has signed a Limitation of Services request. Patient should read the Patient Authorization on the Patient Copy and sign below)

My signature below certifies that I have read, understand, and agree to the Patient Authorization to release my Protected Health Information to Janssen Biotech, Inc., its parent or affiliate, designee or successor, and specialty pharmacies and other service providers supporting Janssen CarePath as defined on the Patient Copy (collectively, "Janssen Biotech").

PATIENT SIGNATURE _____ DATE _____ PATIENT NAME _____

If patient cannot sign, patient's legally authorized representative must sign below.

PATIENT NAME _____ BY _____

(Signature of person legally authorized to sign for patient/relationship)

4. PRESCRIBER INFORMATION (REQUIRED)

PRESCRIBER NAME (First, Last) _____

SPECIALTY _____

PRACTICE NAME _____ OFFICE CONTACT _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

E-MAIL _____ PHONE _____ FAX _____

MEDICAID/MEDICARE PROVIDER# _____ TAX ID# _____

STATE LICENSE# _____ UPIN/NPI# _____

5. PRIOR MEDICATIONS (REQUIRED)

☐ Acetaminophen, ibuprofen, naproxen sodium, or other over-the-counter pain relievers

☐ 5-ASA	☐ Celebrex*	☐ Humira*	☐ Naproxen
☐ 6-MP	☐ Cimzia*	☐ Hydroxychloroquine	☐ Orencia*
☐ Actemra*	☐ Corticosteroids	☐ Indocin*	☐ Otezla*
☐ Azathioprine	☐ Cyclophosphamine	☐ Kineret*	☐ Penicillamine
☐ Azulfidine*	☐ Cyclosporine	☐ Leflunomide	☐ Rituxan*
☐ Calcipotriene	☐ Enbrel*	☐ Methotrexate	☐ Other _____

6. CLINICAL INFORMATION (REQUIRED. Visit JanssenCarePath.com for ICD-10 codes or consult the ICD-10 code book for additional information)

■ **PRIMARY DIAGNOSIS: Rheumatoid Arthritis, Ankylosing Spondylitis, Psoriatic Arthritis, Ulcerative Colitis**

DIAGNOSIS CODE _____ INDICATION _____

■ **SECONDARY DIAGNOSIS: Rheumatoid Arthritis, Ankylosing Spondylitis, Psoriatic Arthritis, Ulcerative Colitis**

DIAGNOSIS CODE _____ INDICATION _____

DIAGNOSIS CODE _____ INDICATION _____

TB TEST (DATE) _____ HEPATITIS B VIRUS TEST (DATE) _____ DATE OF DIAGNOSIS OR YEARS WITH DISEASE _____

7. PRESCRIPTION INFORMATION (If requesting benefits investigation only, do not complete this section. The prescription is only valid if received by fax. If not faxed, prescription must be submitted on state-specific blank, if applicable for your state)

■ **Rx: SIMPONI® (golimumab)**

DIRECTIONS: **RHEUMATOID ARTHRITIS, ANKYLOSING SPONDYLITIS, PSORIATIC ARTHRITIS**

☐ 1 single-use autoinjector, 50 mg/0.5 mL SC once monthly ☐ 1 single-use prefilled syringe, 50 mg/0.5 mL SC once monthly Refills # _____

ULCERATIVE COLITIS—STARTER DOSES

☐ 200 mg at Week 0; 2 single-use autoinjectors, 100 mg/1.0 mL SC ☐ 100 mg at Week 2; 1 single-use autoinjector, 100 mg/1.0 mL SC

☐ 200 mg at Week 0; 2 single-use prefilled syringes, 100 mg/1.0 mL SC ☐ 100 mg at Week 2; 1 single-use prefilled syringe, 100 mg/1.0 mL SC

ULCERATIVE COLITIS—MAINTENANCE THERAPY

☐ 1 single-use autoinjector, 100 mg/1.0 mL SC every 4 weeks ☐ 1 single-use prefilled syringe, 100 mg/1.0 mL SC every 4 weeks Refills # _____

☐ OTHER _____ Refills # _____

■ **PRESCRIBER SIGNATURE (NO STAMPS ALLOWED) REQUIRED TO VALIDATE PRESCRIPTION: I certify that therapy with SIMPONI® is medically necessary for this patient. I will be supervising the patient's treatment accordingly, and I have reviewed the current SIMPONI® 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 _____

SUPERVISING PHYSICIAN SIGNATURE (if applicable) _____ DATE _____

SUPERVISING PHYSICIAN NAME _____

8. PRIOR AUTHORIZATION SERVICES (Automatically provided with benefit investigation. You may opt out by checking the box[es] below)

Prior Authorization Form Assistance Janssen CarePath assists your office in providing the requirements of patient's health plan related to prior authorization for treatment with SIMPONI®. Assistance includes obtaining the health plan-specific prior authorization form, and providing it based upon the patient-specific information provided on this form. The partially completed prior authorization form will be provided to your office for possible completion and submission to the health plan.

I do **NOT** wish to receive Prior Authorization Form Assistance. ☐

Prior Authorization Status Monitoring Janssen CarePath actively monitors the status of prior authorization submission to patient's plan and provides status updates to your office with respect to this patient's prior authorization for treatment with SIMPONI®.

I do **NOT** wish to receive Prior Authorization Status Monitoring. ☐

9. PREFERRED SPECIALTY PHARMACY (Provider to check one below)

As the treating physician, I have discussed preference for a Specialty Pharmacy (SP) with this patient. This patient prefers use of the SP indicated below. I authorize Janssen Biotech, Inc., and its representatives to fax this prescription to: **1.** The SP designated as checked below, provided it is approved by this patient's plan. **2.** If the SP designated is not a plan-approved SP, then to an SP approved by this patient's plan. **3.** If there is no preferred SP indicated, then to any SP approved by this patient's plan.

☐ Accredo ☐ Amber ☐ BioPlus ☐ BriovaRx ☐ CVS Caremark ☐ Cigna ☐ Diplomat ☐ Humana

☐ Modern TLC ☐ Prime Therapeutics SP ☐ Senderra ☐ Walgreens ☐ Other _____

10. SHIPPING INFORMATION (REQUIRED to complete benefit investigation even if not prescribing. NOTE: Shipments cannot be sent to P.O. Boxes)

SHIP TO: ☐ PROVIDER OFFICE—Initial injection only

☐ PATIENT'S HOME—I have instructed the patient in proper injection technique for SIMPONI® and the patient will self-administer ☐ OTHER

NAME _____

ADDRESS _____ CITY _____ STATE _____

ZIP CODE _____ PHONE _____ FAX _____

Please see Important Safety Information and full Prescribing Information, including Boxed Warnings, and Medication Guide for SIMPONI®, available at SIMPONI.com.

 *Indicated trademarks are registered trademarks of their respective owners. Actemra® (tocilizumab), Azulfidine® (sulfasalazine), Celebrex® (celecoxib), Cimzia® (certolizumab pegol), Enbrel® (etanercept), Humira® (adalimumab), Indocin® (indomethacin), Kineret® (anakinra), Orencia® (abatacept), Otezla® (apremilast), Rituxan® (rituximab).

Clear Form Print Form

By providing your information and information about your patient on the front of the Prescription Information and Enrollment 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 see Important Safety Information and full Prescribing Information, including Boxed Warnings, and Medication Guide for SIMPONI® (golimumab), available at SIMPONI.com.

janssen
PHARMACEUTICAL COMPANIES
OF Johnson&Johnson

Patient Copy

Provider Instructions

1. **Have the patient read this form and sign the acknowledgements on the front of the Prescription Information and Enrollment Form relating to the Patient Authorization and Enrollment.**
2. **Provide the patient with this sheet and a copy of the front of the Prescription Information and Enrollment Form, which they have signed.**

PATIENT AUTHORIZATION

My signature on the front of the Prescription Information and Enrollment Form confirms that I authorize each of my physicians, pharmacists, including any specialty pharmacy which receives my prescription for SIMPONI® (golimumab) 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 CarePath programs; (ii) provide me with educational materials, information, and services related to SIMPONI®; (iii) verify, investigate, assist with, and coordinate my coverage for SIMPONI® with my Insurers; (iv) coordinate prescription fulfillment; and (v) assist with analyses related to the quality, efficacy, and safety of SIMPONI®, and patient access to and adherence to SIMPONI®. 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. For additional information on how Janssen Biotech collects, uses, and discloses personal information, visit **JanssenCarePath.com/Privacy-Policy**.

I understand that I am not required to sign the front of the Prescription Information and Enrollment 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 front of the Prescription Information and Enrollment 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 Services. 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, Inc., PO Box 218, Monroeville, PA 15146-2230. 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 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 Biotech.

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit fda.gov/medwatch, or call 800-FDA-1088.
Please read the Medication Guide for SIMPONI® and discuss any questions or concerns with your doctor.

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