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

Janssen CarePath

Treatment Administration Rebate Program
Patient Enrollment Form

Simponi ARIA® golimumab for infusion

*Required

*SELECT ONE: ☐ Enrollment ☐ Update Information Only

Phone: 877-CarePath (877-227-3728) Fax: 844-678-TARP (844-678-8277) MyJanssenCarePath.com
Monday–Friday, 8:00 AM–8:00 PM ET

PATIENT INFORMATION (*Required)

*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

1. Do you currently have commercial or private health insurance that you will use for your Janssen treatment, 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 treatment
   - ☐ No, I do not have commercial or private health insurance that I will use for my Janssen treatment

2. Do you confirm that you will NOT seek reimbursement from any state or federal government-funded healthcare program to cover a portion of the Janssen treatment 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-funded program for my Janssen treatment
   - ☐ No, I may seek reimbursement from a state or federal government-funded healthcare program for my Janssen treatment

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 Treatment Administration Rebate Program for SIMPONI ARIA® (the "Program"). I understand that my personal information will be used by Janssen Biotech, Inc., the maker of SIMPONI ARIA®, 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 treatment administration costs for SIMPONI ARIA®, 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 SIMPONI ARIA®.

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 SIMPONI ARIA® and other Janssen Biotech, Inc., products. If I choose to participate, the information and resources may include providing educational materials related to my treatment. I understand that I am responsible for submitting a rebate request including an Explanation of Benefits (EOB) and proof of provider payment for my out-of-pocket treatment administration costs to receive payment under the Treatment Administration Rebate Program. The Program will use the information I submit to determine the amount of treatment administration costs for SIMPONI ARIA® that Janssen Biotech, Inc., will reimburse. That amount will be issued via check payable to me. I further understand that if I do not submit an EOB and proof of provider payment, the Program cannot process my rebate request.

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.

Mail or fax completed enrollment form to: Mail: Janssen CarePath Treatment Administration Rebate Program, 2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560 Fax: 844-678-TARP (844-678-8277)

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 _____

3 ways for patient to enroll: Review the program requirements on the next page, then choose the enrollment option you prefer:

Online at MyJanssenCarePath.com
To access the enrollment site, you will need to create an account if you don't already have one.

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

Mail or Fax
Complete and sign this form above and mail or fax to:
Mail: Janssen CarePath Treatment Administration Rebate Program
2250 Perimeter Park Drive, Suite 300
Morrisville, NC 27560
OR
Fax: 844-678-TARP (844-678-8277)

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

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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 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, and Janssen CarePath Account for Patients.

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 treatment support programs; (ii) provide me with educational materials, information, and services related to my Janssen treatment; (iii) verify, investigate, assist with, and coordinate my coverage for my Janssen treatment with my Insurers; (iv) assist with analyses related to the quality, efficacy, and safety of my Janssen treatment, and patient access to and adherence to my Janssen treatment; (v) share and provide access to information generated by Janssen CarePath that may be useful for my care; and (vi) improve, develop, and evaluate Janssen CarePath, its offerings, and materials. 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 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 Treatment Administration Rebate Program

Benefits are available to individuals age 2 or older using commercial or private health insurance to cover a portion of the treatment costs for SIMPONI ARIA® (golimumab). There is no income requirement. Janssen CarePath Treatment Administration Rebate Program for SIMPONI ARIA® is based on infusion administration costs only and does not include medication costs.

For medication cost support, we offer the Janssen CarePath Savings Program. Learn more at SimponiAria.JanssenCarePathSavings.com.

Other Requirements:

- **This program is only available to individuals age 2 or older using commercial or private health insurance for their Janssen treatment, 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 treatment 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).
- Your eligibility to receive a rebate is subject to meeting the program requirements at the time of each rebate request.
- Program terms will expire at the end of each calendar year. Program subject to change or discontinuation without notice, including in specific states. Not valid for residents of MA, MI, MN, or RI.
- 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.
- Before you complete enrollment, it is important that you understand that you will be asked to provide personal information that may include your name, address, phone number, e-mail address, and information related to your healthcare insurance and treatment. This information is necessary to permit Janssen Biotech, Inc., the maker of SIMPONI ARIA®, 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 Treatment Administration Rebate Program. We may also use the information you give us to learn more about the people who use SIMPONI ARIA® and to improve the information we provide to people who are being treated with SIMPONI ARIA®. Janssen Biotech, Inc., will not share your information with anyone else except as required by law.
- You are responsible for submitting a rebate request including an Explanation of Benefits (EOB) and proof of provider payment to receive payment under the Treatment Administration Rebate Program.
- This program offer may not be combined with any other coupon, discount, free trial, or other offer covering treatment administration. Offer good only in the United States and its territories, excluding states noted above. 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).

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 SIMPONI ARIA®, and discuss any questions you have with your doctor.

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