



Treatment Administration Rebate Program Rebate Form

Complete this form only if:

- You are submitting your rebate by mail or fax, **OR**
- You are submitting your rebate online in your MyJanssenCarePath.com account AND you are unable to obtain proof of provider payment (eg, receipt for treatment administration costs from treatment provider). Your treatment site representative is required to sign this form if you do not have a receipt.

Here's how to receive a rebate for your out-of-pocket treatment administration costs:

- You must be enrolled in the Janssen CarePath Treatment Administration Rebate Program before receiving a rebate. You can enroll by calling 877-CarePath (877-227-3728), online at MyJanssenCarePath.com, or complete and submit the enrollment form.
- You must complete the information below and sign the form.
- You are responsible for submitting the following documents:
 - Explanation of Benefits (EOB) from your primary healthcare insurance provider (as well as any secondary insurance provider, if applicable);
 - Receipt from your treatment provider indicating payment of your out-of-pocket treatment administration costs. Valid receipt will include your name, medication (name, J code, or NDC#), date, and amount you paid for treatment administration.
 If you do not have a receipt for payment for the treatment administration, you must obtain your treatment site representative's signature below.
- If you are eligible, you will receive a rebate check in about 2-3 weeks.

Complete the information below. *Required

The information you provide will only be used by Janssen Biotech, Inc., our affiliates, and our service providers, to provide benefits to you related to your participation in the Janssen CarePath Treatment Administration Rebate Program for SIMPONI ARIA[®]. If you want to stop receiving this information or service, you may withdraw from the program by calling 877-CarePath (877-227-3728). Our [Privacy Policy](#) governs the use of the information you provide.

*Name	E-mail	*Phone	
			Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
*11-digit Member ID# (issued with enrollment confirmation)		*Date of Birth (mm/dd/yyyy)	
*Address	*City	*State	*Zip

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). This program is only available to individuals age 18 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.

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. 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. 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.** Offer good only in the United States and its territories, excluding states noted above. Void where prohibited, taxed, or otherwise restricted by law. REBATE FORM CANNOT BE BOUGHT, TRANSFERRED, OR SOLD. REBATE FORM CANNOT BE COMBINED WITH ANY OTHER OFFER, DISCOUNT, OR FREE TRIAL COVERING TREATMENT ADMINISTRATION. Use of this program is subject to the program eligibility requirements, which can be found on the Janssen CarePath Treatment Administration Rebate Program Brochure.

By signing, dating, and submitting this form you confirmed that **you have already enrolled in Janssen CarePath Treatment Administration Rebate Program. Janssen CarePath cannot process this rebate form if you are not enrolled in the program.** In addition, you indicate you read, understand, agree, and meet the terms and conditions on this form, as well as the eligibility requirements which were explained to you when you enrolled in the program, which may also be found in the Janssen CarePath Treatment Administration Rebate Program Brochure.

*Patient Signature		*Date	
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Treatment site representative signature required ONLY if proof of provider payment is not available. By signing below, you are confirming the patient has paid for his/her out-of-pocket treatment administration costs and was treated with SIMPONI ARIA[®] (J1602) on the date below.

*Treatment Site Representative Signature	*Print Name	*Date
*Treatment Site Name/location		*Date of Treatment

You can submit by mail, fax or online (if required):



Mail:
Janssen CarePath
Treatment Administration Rebate Program
2250 Perimeter Park Drive, Suite 300
Morrisville, NC 27560



Fax:
844-678-TARP
(844-678-8277)



Online:
MyJanssenCarePath.com

Complete & submit this form online if treatment site representative signature is required for proof of provider payment.

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