

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 _____ **Secondary Insurance** _____
 Policy # _____ Policy # _____
 Group # _____ Group # _____
 Policy Holder's Name _____ Policy Holder's Name _____
 Insurance Co. Phone _____ 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 SIMPONI ARIA[®]. 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 SIMPONI ARIA[®].

7. Therapy with SIMPONI ARIA[®]

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 SIMPONI ARIA[®]: 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 SIMPONI ARIA[®] is medically necessary for this patient. I will be supervising the patient's treatment accordingly and I have reviewed the current SIMPONI ARIA[®] 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 SIMPONI ARIA[®], please see full [Prescribing Information](#), including [Boxed Warnings](#) and [Medication Guide](#) for SIMPONI ARIA[®], available at SimponiAria.com/hcp. Provide the Medication Guide to your patients and encourage discussion.

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.

Janssen Biotech, Inc., 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, Inc., 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.