Janssen CarePath

UPDATE 3.17

Benefit Investigation and Prescription Form

Complete and fax this form to 866-769-3903.
For assistance, call 877-CarePath (877-227-3728), Monday–Friday, 8:00 AM–8:00 PM, ET

Stelara® (ustekinumab)

1. PATIENT INFORMATION (REQUIRED)

NAME (First, MI, Last) _____ SEX ☐ M ☐ F

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____ DOB (MM/DD/YYYY) _____

PRIMARY PHONE (best number to call 8:00 AM to 8:00 PM) _____

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, specialty pharmacies, and other service providers supporting Janssen CarePath as defined on the Patient Copy (collectively, "Janssen Biotech").

PATIENT SIGNATURE _____ DATE _____

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

PATIENT NAME _____

PATIENT NAME _____ BY _____

Signature of person legally authorized to sign for patient/relationship

NURSE NAVIGATORS FROM JANSSEN CAREPATH (Patient Enrolled Program)

☐ YES! I (the patient) would like to receive information about the Nurse Navigator Program and how it can support me on my treatment journey with STELARA®.

☐ YES! I (the patient) would like to enroll in the Nurse Navigator Program and will submit the attached enrollment form.

2. INSURANCE INFORMATION (REQUIRED. Complete fields below OR provide a copy of insurance cards)

☐ Copies of patient's insurance cards are included with this form.

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 _____

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

STELARA®—DIAGNOSIS

☐ K50.00 (Crohn's Disease of small intestine, without complications)
☐ K50.80 (Crohn's Disease of both small and large intestine, without complications)
☐ K50.90 (Crohn's Disease, unspecified, without complications)
☐ Other ICD-10 Code _____

DATE OF DIAGNOSIS OR YEARS WITH DISEASE _____ PREVIOUS TB TEST (DATE) _____

PRIOR MEDICATIONS (REQUIRED TO COMPLETE PRIOR AUTHORIZATION)

☐ 5-ASA ☐ 6-MP ☐ Azathioprine ☐ Azulfidine* ☐ Cimzia* ☐ Cyclosporine
☐ Corticosteroids ☐ Entyvio* ☐ Humira* ☐ Methotrexate ☐ None ☐ Other _____

4. PRESCRIBER INFORMATION (REQUIRED)

PRESCRIBER NAME (First, Last) _____

SPECIALTY _____

PRACTICE NAME _____ OFFICE CONTACT _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

PHONE _____ FAX _____

TAX ID# _____ NPI# _____

5. SINGLE IV INDUCTION AND SITE OF INFUSION INFORMATION (Complete this section if patient has not received induction dose. If requesting benefits investigation or prescription for maintenance dose only, skip to Section 6.)

INFUSION INDUCTION DOSE

☐ 55 kg or less — 260 mg (2 x 130 mg vials) at Week 0
☐ more than 55 kg to 85 kg — 390 mg (3 x 130 mg vials) at Week 0
☐ more than 85 kg — 520 mg (4 x 130 mg vials) at Week 0

PATIENT WEIGHT _____ lb. _____ kg.

SITE OF INFUSION (REQUIRED IF DIFFERENT FROM PRESCRIBING MD's OFFICE)

☐ Non-prescribing MD's office ☐ Hospital outpatient ☐ Infusion Center ☐ Other

PHYSICIAN OR INFUSION PROVIDER NAME _____

PRACTICE/FACILITY NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____ FAX _____

NPI # _____ TAX ID # _____

6. MAINTENANCE DOSE PRESCRIPTION (Complete this section if requesting benefits investigation or prescription for maintenance dose. 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)

☐ I would like to investigate benefits for two STELARA® 45 mg vials for maintenance therapy (HCP-administered)

Rx STELARA® MAINTENANCE THERAPY ☐ 1 single-use prefilled syringe; **90 mg** SC every 8 weeks Refills # _____

REQUESTED SHIP DATE _____ DATE OF INFUSION INDUCTION DOSE (IF KNOWN) _____

SHIPPING INFORMATION FOR MAINTENANCE THERAPY (Required to compete benefits investigation even if not prescribing. NOTE: Shipments cannot be sent to P.O. Boxes)

SHIP TO: ☐ Office ☐ Patient (Payer may require pharmacy benefit use only if selected) ☐ Hospital Outpatient ☐ Other

ADDRESS _____ CITY _____

STATE _____ ZIP CODE _____ PHONE _____ FAX _____

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

7. PREFERRED SPECIALTY PHARMACY

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 as designated below, provided it is approved by this patient's plan. **2.** If the SP designated is not a plan-approved SP, then to a 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.

PHARMACY NAME _____ PHONE _____

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

Prior Authorization Form Assistance and Status Monitoring: Janssen CarePath assists your office in providing the requirements of the patient's health plan related to prior authorization for treatment with STELARA®. 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. Janssen CarePath also actively monitors the status of prior authorization submission to the patient's plan and provides status updates to your office with respect to this patient's prior authorization for treatment with STELARA®.

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

Please click to read the Indications, Important Safety Information, full Prescribing Information and Medication Guide for STELARA® (ustekinumab), available at StelaraHCP.com.

By providing your information and information about your patient on the front of the Benefit Investigation and Prescription 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 click to read the Indications, Important Safety Information, full Prescribing Information and Medication Guide for STELARA® (ustekinumab), available at StelaraHCP.com.

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Patient Copy

Provider Instructions

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

PATIENT AUTHORIZATION

My signature on the front of the Benefit Investigation and Prescription Form confirms that I authorize each of my physicians, pharmacists, including any specialty pharmacy that receives my prescription for STELARA® (ustekinumab) 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 STELARA®; (iii) verify, investigate, assist with, and coordinate my coverage for STELARA® with my Insurers; (iv) coordinate prescription fulfillment; and (v) assist with analyses related to the quality, efficacy, and safety of STELARA®, and patient access to and adherence to STELARA®. 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 Benefit Investigation and Prescription 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 Benefit Investigation and Prescription 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. 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., P.O. 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/safety/medwatch, or call 800-FDA-1088.

Please click to read the Medication Guide for STELARA® and discuss any questions you have with your doctor.

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Janssen CarePath

Nurse Navigators from Janssen CarePath Enrollment Form

Stelara® (ustekinumab)

Fax to:
800-870-6237

Mail to:
Nurse Navigators from Janssen CarePath
500 Atrium Drive, 3rd Floor, Somerset, NJ 08873

E-mail to:
mynurse@janssennurse.com

***REQUIRED INFORMATION**

1. PATIENT INFORMATION

☐ Mr ☐ Mrs ☐ Ms ☐ Miss

*FIRST NAME _____

*LAST NAME _____

STREET ADDRESS _____ APT/UNIT _____

CITY _____ STATE _____

ZIP CODE _____ *PHONE _____ ☐ Mobile ☐ Home ☐ Office ☐ Other

Okay to leave message? ☐ Yes ☐ No Okay to text? ☐ Yes ☐ No

*EMAIL ADDRESS _____ DOB (MM/DD/YYYY)_____

I authorize the following individual to act as my personal representative in this program

_____

Relationship to you

_____

2. PHYSICIAN INFORMATION (OPTIONAL)

☐ Doctor ☐ Nurse Practitioner ☐ Physician Assistant

NAME _____

STREET ADDRESS _____

CITY _____ STATE _____

ZIP CODE _____ PHONE _____

3. PATIENT AUTHORIZATION (SIGNATURE REQUIRED)

My signature on the Nurse Navigator Enrollment Form confirms I authorize each of my physicians ("healthcare providers") to disclose my protected health information, including information related to my medical condition and treatment, to Janssen Biotech, Inc., its affiliated companies, agents, and representatives, including other service providers supporting access programs for healthcare providers and patients (STELARA® and Nurse Navigators from 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 Nurse Navigators from Janssen CarePath; (ii) provide me with educational materials, information, and services related to Nurse Navigators from Janssen CarePath; and (iii) adherence to STELARA®. I also understand that information regarding my participation in Nurse Navigators from Janssen CarePath will be shared with my prescribing physician. 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 http://janssen.com/privacy-policy.

I understand that I am not required to sign the Nurse Navigator Enrollment Form. My choice about whether to sign will not change the way my healthcare providers treat me. If I do not sign the Nurse Navigator Enrollment Form, or revoke my authorization later, I understand that this means I will not be able to participate in Nurse Navigators from Janssen CarePath.

This authorization will last until I am no longer participating in Nurse Navigators from Janssen CarePath. I understand that I may cancel this authorization at any time by mailing a letter requesting such cancellation to:

Nurse Navigators from Janssen CarePath
500 Atrium Drive, 3rd Floor, Somerset, NJ 08873

I can also revoke my authorization by informing my healthcare providers 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 Nurse Navigators from Janssen CarePath is discontinued. Furthermore, I understand that I have the right to see or copy the protected health information my healthcare providers have given to Janssen Biotech.

PATIENT AUTHORIZATION SIGNATURE _____

DATE _____

Please click to read the Medication Guide for STELARA® and discuss any questions you have with your doctor.

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