Janssen CarePath Savings Program
Patient Assignment of Benefits

1. **Please note that this completed form is required in order for the provider to receive a check payment on behalf of the patient for medication costs.**
2. **The patient must authorize by signing this form. All fields must be completed.**
3. **Completed form may be faxed to Janssen CarePath at 844-250-7193, or mailed to Janssen CarePath, 2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560.**

Treatment Provider Information and Authorization

Site Name: NPI:

Provider First Name: Provider Last Name:

Address: City: State: ZIP:

Site Phone: Site Fax:

My signature on this Patient Assignment of Benefits Form acknowledges that the patient listed below has requested rebate checks from the Janssen CarePath Savings Program be sent to our Treatment Site for payment of the patient's eligible out-of-pocket Janssen medication costs. I further understand that patient may elect in the future for the rebate check(s) to be sent directly to the patient or for the rebate to be loaded onto a debit card (if available). At that point, check(s) will no longer be sent to our Treatment Site.

Treatment Site Representative Signature: _____ Date:

Print Name: Treatment Site:

Patient Information and Authorization

Patient: Date of Birth (mm/dd/yyyy):

Patient address:

City: State: ZIP Code:

My signature on this Patient Assignment of Benefits Form confirms that I authorize each of my Janssen CarePath Savings Program rebate check(s) be sent on my behalf to the provider I have designated on this form for payment of my out-of-pocket Janssen medication cost. I also understand that I may, at any time, call Janssen CarePath and elect for the rebate check(s) to be sent directly to me or for my rebate to be loaded onto a debit card (if available).

Patient Signature: _____ Date: _____

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

By: _____ Date: _____

(Signature of person legally authorized to sign for patient)

Describe relationship to patient and authority to make medical decisions for patient: _____

Please read the full Prescribing Information and Medication Guide for STELARA®, and discuss any questions you have with your doctor.