Janssen CarePath UPDATE 3.17

PsO/PsA Benefit Investigation and Prescription Form

Complete and fax this form to 866-769-3903 or mail to P.O. Box 218, Monroeville, PA 15146-2230.
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) _____

2. INSURANCE INFORMATION (REQUIRED. Include alpha prefix and suffix with policy and group# when applicable or provide a copy of insurance cards)

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 (REQUIRED. Visit JanssenCarePath.com for ICD-10 codes or consult the ICD-10 code book for additional information)

PRIMARY DIAGNOSIS: **PSORIASIS** ☐ L40.00 (Psoriatic vulgaris) ☐ Other ICD-10 Code _____

PSORIATIC ARTHROPATHY ☐ L40.50 (Arthropathic psoriasis, unspecified) ☐ Other ICD-10 Code _____

SECONDARY DIAGNOSIS: ICD-10 CODE _____

TB TEST DATE _____ DATE OF DIAGNOSIS OR YEARS WITH DISEASE _____

PATIENT WEIGHT _____ lb. _____ kg. % BSA AFFECTED _____

4. PRESCRIBER INFORMATION (REQUIRED)

PRESCRIBER NAME (First, Last) _____

SPECIALTY _____

PRACTICE NAME _____ OFFICE CONTACT _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

PHONE _____ FAX _____ TAX ID# _____

MEDICAID/MEDICARE PROVIDER# _____ NPI# _____

Please click to read the full Prescribing Information and Medication Guide for STELARA®, also available at StelaraHCP.com.

5 . PRIOR THERAPIES (REQUIRED to complete Prior Authorization Form Assistance)

☐ Corticosteroids ☐ Cyclosporine ☐ Enbrel* ☐ Humira* ☐ Methotrexate
☐ Otezla* ☐ Phototherapy ☐ Soriatane* ☐ None of the above ☐ Other _____

6. PRESCRIPTION INFORMATION (If requesting benefits investigation only, do not complete this section. 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)

Rx DIRECTIONS

STARTER DOSES REQUESTED SHIP DATE _____

☐ 2 single-use prefilled syringes; **45 mg** SC at Week 0 and Week 4

☐ 2 single-use prefilled syringes; **90 mg** SC at Week 0 and Week 4

MAINTENANCE THERAPY REQUESTED SHIP DATE _____

☐ 1 single-use prefilled syringe; **45 mg** SC every 12 weeks Refills # _____

☐ 1 single-use prefilled syringe; **90 mg** SC every 12 weeks Refills # _____

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. BENEFIT INVESTIGATION

☐ **I would like to request investigation of benefits only for STELARA® at this time** ☐ 45 mg single-use prefilled syringe ☐ 90 mg single-use prefilled syringe

☐ **I would like to request investigation of Medical benefits for STELARA® 45 mg single dose vial** ☐ 1 vial ☐ 2 vials

SITE OF CARE (Complete if different than Prescribing MD's Office)

☐ Non-prescribing MD's office ☐ Hospital outpatient ☐ Home infusion/Infusion Provider Company ☐ Other

PHYSICIAN OR INFUSION PROVIDER NAME _____

PRACTICE/FACILITY NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

PHONE _____ FAX _____ CONTACT NAME _____

INSURANCE PROVIDER# _____ TAX ID# _____

8. PRIOR AUTHORIZATION SERVICES (Automatically provided with benefit 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. ☐

Janssen CarePath cannot accept any information without an executed Business Associate Agreement or Patient Authorization Form which can be found at JanssenCarePath.com. In addition, a Patient Authorization Form can be found as the last page of this document.

By providing your information and information about your patient on the front of the Prescription Information and Enrollment 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 full Prescribing Information and Medication Guide for STELARA® (ustekinumab), also available at StelaraHCP.com. Provide the Medication Guide to your patients and encourage discussion.

janssen
PHARMACEUTICAL COMPANIES
OF Johnson&Johnson

 3/17 067889-170223

PATIENT AUTHORIZATION FORM FOR STELARA® (ustekinumab)

Provider Instructions

- **To be completed only when (1) there is not a valid Business Associate Agreement, or (2) the Covered Entity has signed a Limitation of Services request.**
- **Patients should read the Patient Authorization and sign below.**
- **A copy of this form must be provided to the patient.**

PATIENT AUTHORIZATION

My signature on this Patient Authorization Form confirms that I authorize each of my physicians, pharmacists, including any specialty pharmacy which receives my prescription for a Janssen medication 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 medication Support programs; (ii) provide me with educational materials, information, and services related to my Janssen medication; (iii) verify, investigate, assist with, and coordinate my coverage for my Janssen medication with my Insurers; (iv) coordinate prescription fulfillment; and (v) assist with analyses related to the quality, efficacy, and safety of my Janssen medication, and patient access to and adherence to my Janssen medication. 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.

I understand that I am not required to sign this Patient Authorization 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 Patient Authorization 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, P.O. Box 220829, Charlotte, NC 28222-0829. 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 Support programs are 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.

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

Patient address: _____ City: _____ State: _____ ZIP Code: _____

Patient sign here: _____ Date: _____

If 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: _____

Fax completed form to 866-489-5955 or mail to Janssen CarePath, P.O. Box 220829, Charlotte, NC 28222-0829

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