

Rebate Request Fax Cover Sheet

FAX TO: 844-250-7193

Please include your patients' Explanation of Benefits (EOBs) and FAX to Janssen CarePath Savings Program.

Including this cover sheet, this rebate request submission includes _____ pages.

Number of STELARA[®] patients included in this fax: _____

Please confirm EOBs in this fax are for STELARA[®] Patients ONLY:

(Please note that we can only accept faxes with information for patients receiving treatment with Janssen medications.)

Please note: If you are submitting an EOB which does not include the J-code or the name of the medication, please include a completed EOB Clarification Form available at JanssenCarePath.com with your completed Fax submission.

By providing your information and information about your patients, you are requesting the services described on this form. The information will be used by Janssen Biotech, Inc., our affiliates, and our service providers to determine if a patient is eligible for benefits related to their participation in Janssen CarePath Savings Program. You may withdraw your request by calling 877-CarePath (877-227-3728). Our [Privacy Policy](#) governs the use of the information you provide.

Practice/Business Name _____

Your Name _____

Address _____

City _____ State _____ ZIP Code _____

Primary Phone (Best number to call between 8:00 AM–8:00 PM ET, weekdays) _____

Email _____ Office–Main Fax _____

Additional Information:

Please read the full [Prescribing Information](#) and [Medication Guide](#) for STELARA[®], available at JanssenCarePath.com.
Provide the Medication Guide to your patients and encourage discussion.