Janssen CarePath

Update 11.17

Savings Program
877-CarePath (877-227-3728)
Monday–Friday, 8:00 AM–8:00 PM ET

Stelara® (ustekinumab)

Medical Benefit Rebate Form

Complete this side of form if you are submitting an **Explanation of Benefits (EOB)** and you want to receive a rebate check.

Your Rebate in 4 Easy Steps

1. You must be enrolled in the Janssen CarePath Savings Program before receiving your Janssen medication. You can enroll by calling 877-CarePath (877-227-3728) or online at **Stelara.JanssenCarePathSavings.com**.
2. Complete the information below and sign the form.
3. Include a copy of the following documents:
   - Explanation of Benefits (EOB) from your primary insurance provider (as well as any secondary insurance provider, if applicable);
   - Receipt from your treatment provider indicating proof of payment of your out-of-pocket Janssen medication costs. Valid receipt will include your name, medication, date, and amount of your out-of-pocket responsibility paid for your medication.

   If you do not have proof of payment for your medication, you must obtain your Provider's signature below.
4. Submit this signed form online, by fax, or by mail along with EOB and proof of payment (see below for details). Eligible patients will receive a rebate check in about three weeks.

If you are submitting a **pharmacy receipt** and want to receive a rebate check, only complete the Pharmacy Benefit Rebate Form on the other side.

Complete the information below. *Required

The information you provide will only be used by Janssen Biotech, Inc., our affiliates, and our service providers, to provide benefits to you related to your participation in the Janssen CarePath Savings Program for STELARA®. If you want to stop receiving this information or service, you may withdraw from the program by calling 877-CarePath (877-227-3728). Our **Privacy Policy** governs the use of the information you provide.

*Name _____ E-mail _____ *Phone _____

*11-digit ID# found on the front of the card _____ *Date of Birth (mm/dd/yyyy) _____ Gender ☐ Male ☐ Female

*Address _____ *City _____ *State _____ *Zip _____

By redeeming this rebate, you certify that you will not submit a claim for amounts covered by this rebate for payment to any third-party payers, or from pharmaceutical patient assistance foundations and accounts, including a Flexible Spending Account (FSA), a Health Savings Account (HSA), or a Health Reimbursement Account (HRA).

This program is only available to individuals using private or commercial health insurance to cover a portion of their medication costs, including plans available through state and federal healthcare exchanges. This program is not available to individuals who use any state or federal government-subsidized healthcare program to cover a portion of medication costs, such as Medicare, Medicaid, TRICARE, Department of Defense, or Veterans Administration.

Offer valid only for the product indicated. Any other use may constitute fraud. The selling, purchasing, trading, or counterfeiting of this rebate form is prohibited by federal law, and such activities may result in imprisonment for not more than 10 years or fines not more than $250,000, or both. REBATE FORM CANNOT BE BOUGHT, TRANSFERRED, OR SOLD. REBATE FORM CANNOT BE COMBINED WITH ANY OTHER OFFER, DISCOUNT, PRESCRIPTION SAVINGS CARD, OR FREE TRIAL. Customer is responsible for any sales tax. Tax charged on prerebate price where required. No cash back. Offer good only in the U.S. and Puerto Rico. Janssen Biotech, Inc., reserves the right to rescind, revoke, or amend this offer without notice at any time. Void where prohibited, taxed, or otherwise restricted by law. **As a condition of participating in this program, you must ensure that you comply with any co-payment disclosure requirements of your insurance carrier or third-party payer, including disclosing to your insurer the amount of co-payment support you receive from this program.**

Use of this card is subject to the program eligibility requirements, which can be found on the Janssen CarePath Savings Program for STELARA® Brochure. **Offer for new enrollment expires December 31, 2018. For Massachusetts residents only, this offer is subject to change per state legislation.**

By signing, dating, and submitting this form, you confirmed that **you have already enrolled in the Janssen CarePath Savings Program before receiving your medication. Janssen CarePath cannot process the rebate form if you have not completed this process.** In addition, you indicate you read, understand, agree, and meet the terms and conditions on this form, as well as the eligibility requirements which were explained to you when you received the card, which may also be found in the Janssen CarePath Savings Program for STELARA® Brochure or online at **Stelara.JanssenCarePathSavings.com**.

*Patient Signature _____ *Date _____

Provider signature required ONLY if proof of payment is not provided with rebate request. By signing below, you are confirming the patient has paid for his/her out-of-pocket medication costs and was treated with STELARA® (J3357) on the date below.

*Provider Signature _____ *Print Name _____ *Date _____

*Treatment Site Name/location _____ *Date of Treatment _____

You can submit online, by fax, or by mail:

Online:
Stelara.JanssenCarePathSavings.com

Fax:
844-250-7193

Mail:
Janssen CarePath Savings Program
2250 Perimeter Park Drive, Suite 300
Morrisville, NC 27560

You will receive your rebate check in about three weeks.

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

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Pharmacy Benefit Rebate Form

Complete this side of form if you are submitting a **pharmacy receipt** and you want to receive a rebate check.

Your Rebate in 4 Easy Steps

1. You must be enrolled in the JanssenCarePath Savings Program before receiving your Janssen medication. You can enroll by calling 877-CarePath (877-227-3728) or online at **Stelara.JanssenCarePathSavings.com**.
2. Complete the information below and sign the form.
3. Include a copy of the pharmacy receipt. Valid receipt will include your name, medication, date, and amount paid for your STELARA® medication.

   If your receipt includes a prescription number and does not include Janssen medication name, also include a copy of your prescription label from the medication carton.
4. Submit this signed form online, by fax, or by mail along with your pharmacy receipt and prescription label from medication carton, if required (see below for details). Eligible patients will receive a rebate check in about three weeks.

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*Address _____ *City _____ *State _____ *Zip _____

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Morrisville, NC 27560

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