Janssen CarePath UPDATE 4.17

Benefit Investigation Form

Complete and fax this form to 855-998-4422 or mail to P.O. Box 59, Monroeville, PA 15146-2230. Complete Sections 7 & 8 if you also request Janssen CarePath to assist your office with prescribing ZYTIGA® and streamlining the prescription fulfillment process. Janssen CarePath will provide you with a verification of benefits within 4-6 business hours and contact your patient to explain benefits, and offer support services.*

Zytiga® abiraterone acetate

1. PATIENT INFORMATION (REQUIRED)

NAME (First, MI, Last)_____ LANGUAGE ☐ ENGLISH ☐ SPANISH

DOB (MM/DD/YYYY) _____ ADDRESS_____

CITY_____ STATE_____ ZIP CODE_____ E-MAIL_____

HOME/CELL PHONE_____ WORK PHONE_____ BEST TIME TO CONTACT_____

Complete the caregiver information below only if you authorize or prefer that your caregiver be contacted in place of you. (Patient Authorization must be completed below to authorize the caregiver.)

CAREGIVER/CONTACT_____ HOME PHONE_____

CELL PHONE_____ BEST TIME TO CONTACT_____

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_____ INS. CO. PHONE_____

POLICY#_____ GROUP#_____

SECONDARY INSURANCE_____ CARDHOLDER_____

RELATIONSHIP TO CARDHOLDER_____ INS. CO. PHONE_____

POLICY#_____ GROUP#_____

PRESCRIPTION DRUG INSURER_____ CARD/BIN#_____ PHONE_____

3. PRESCRIBER INFORMATION (REQUIRED)

PRESCRIBER NAME (First, Last)_____

SPECIALTY_____

PRACTICE NAME _____ OFFICE CONTACT_____

ADDRESS_____

CITY_____ STATE_____ ZIP CODE_____

PHONE_____ FAX_____

MEDICAID/MEDICARE PROVIDER#_____ TAX ID#_____

STATE LICENSE#_____ UPIN/NPI#_____

4. PATIENT AUTHORIZATION (To be completed if there is not a valid Business Associate Agreement with the Covered Entity. 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., and companies working on their behalf, including vendors, other affiliates, specialty pharmacies, and other service providers supporting Janssen CarePath as defined on the Patient Copy (collectively, "Janssen Biotech").

☐ **I authorize Janssen CarePath to leave a message, including the prescription name ZYTIGA®, if I am unavailable when they call.**

☐ **If I cannot be reached, I authorize Janssen CarePath to contact my caregiver.** ☐ **I prefer and authorize Janssen CarePath to contact my caregiver in place of me.**

PATIENT SIGNATURE ››_____ DATE_____

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

PATIENT NAME_____ BY_____

(Signature of person legally authorized to sign for patient/relationship)

NAME OF PERSON LEGALLY AUTHORIZED TO SIGN_____ RELATIONSHIP_____

5. PRIOR AUTHORIZATION SERVICES (Please check the appropriate box[es] below to request assistance with prior authorizations)

☐ **Prior Authorization Form Assistance** By checking this box, I request that Janssen CarePath assist my office in providing the requirements of this patient's health plan related to prior authorization for treatment with ZYTIGA®. I understand that assistance includes obtaining the health plan-specific prior authorization form, and providing it based upon the patient-specific information provided on this form. I understand that the partially completed prior authorization form will be provided to my office by Janssen CarePath for possible completion and submission to the health plan.

☐ **Prior Authorization Status Monitoring** By checking this box, I request that Janssen CarePath actively monitor the status of the prior authorization submission. I request that Janssen CarePath provide status updates to my office with respect to this patient's prior authorization for treatment with ZYTIGA®.

6. CLINICAL INFORMATION (REQUIRED)

DIAGNOSIS CODE: ☐ C61 Malignant neoplasm of prostate ☐ COMMENT/OTHER_____

7. PRESCRIPTION INFORMATION (If requesting benefits investigation only, do not complete this section. The prescription is only valid if received by fax. SPECIAL NOTE: New York Prescribers please submit prescription on an original NY State prescription blank. For all other states, if not faxed, prescription must be submitted on state-specific blank, if applicable for your state)

Rx **ZYTIGA® (abiraterone acetate)** ☐ **250 mg tablet** ☐ **500 mg film-coated tablet**

DIRECTIONS: Take _____ mg PO _____ daily on an empty stomach. **QUANTITY:**_____ **REFILLS #**_____

Initial Dosing: For patients with baseline moderate hepatic impairment (Child-Pugh Class B), reduce the ZYTIGA® starting dose to 250 mg once daily (see Dose Modification Guidelines for more information). Do not use ZYTIGA® in women who are or may become pregnant and patients with baseline severe hepatic impairment (Child-Pugh Class C). Refer to the ZYTIGA® full PRESCRIBING INFORMATION, including the following sections: INDICATIONS AND USAGE, CONTRAINDICATIONS, DOSAGE AND ADMINISTRATION, WARNINGS AND PRECAUTIONS, ADVERSE REACTIONS, DRUG INTERACTIONS, and USE IN SPECIFIC POPULATIONS prior to initiating treatment.

Rx **Prednisone** ☐ **5 mg tablet**

DIRECTIONS: Take _____ **QUANTITY:**_____ **REFILLS #**_____

Prednisone is required to be taken with ZYTIGA®, however optional to include on this Benefit Investigation Form. You may provide a prescription direct to the patient to be filled at a pharmacy that can fill the script. NOTE: Janssen CarePath will not investigate benefits for prednisone. Please refer to full Prescribing Information for complete information prior to initiating treatment.

NAME (if different from above)_____

ADDRESS_____

CITY_____ STATE_____ ZIP CODE_____

PHONE_____ FAX_____

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

PRESCRIBER SIGNATURE ›› (Substitutions allowed)_____ DATE_____

SUPERVISING PHYSICIAN SIGNATURE ›› (if applicable)_____ DATE_____

SUPERVISING PHYSICIAN NAME_____

8. PREFERRED PHARMACY (Provider to check one below)

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 designated as checked 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.

☐ Accaria	☐ Accredo	☐ Advanced Care Scripts	☐ BioPlus	☐ ICORE	☐ OncologyRx	☐ Prime
☐ Aetna	☐ Amber	☐ Avella (Apothecary Shops)	☐ CVS Caremark	☐ Onco360	☐ RightSource Rx	☐ TLC Rx
☐ Axium	☐ Biologics	☐ CIGNA Tel-Drug	☐ Diplomat	☐ OptumRx	☐ US Bioservices	☐ Walgreens

☐ Other Pharmacy/Self-Dispensing Practice _____

Before prescribing ZYTIGA®, please see full Prescribing Information available at ZYTIGAHCP.com. For assistance or additional information, call 877-CarePath (877-227-3728), Monday–Friday, 8:00 AM–8:00 PM ET.

*Janssen CarePath will not contact patients after the insurance benefit investigation if there is a Limitation of Services on file, and if the patients did not request these services by contacting Janssen CarePath directly or providing Patient Authorization.

Clear Form Print Form

By providing your information and information about your patient on the front of the Benefit Investigation 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 support services administrator under contract for Janssen Biotech, Inc. In this regard, the support services administrator 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 support services administrator, 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 support services administrator tries to provide correct information, it and Janssen Biotech make no representations or warranties, expressed or implied, as to the accuracy of the information. In no event shall the support services administrator, 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, 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.

Before prescribing ZYTIGA® (abiraterone acetate), please see full Prescribing Information available at ZYTIGAHCP.com.

Janssen Biotech, Inc.

Janssen
PHARMACEUTICAL COMPANIES
OF Johnson&Johnson

Patient Copy

Provider Instructions

1. **Have the patient read this form and sign the acknowledgement on the front of the Janssen CarePath Patient Enrollment Form relating to the Patient Authorization.**
2. **Provide the patient with this sheet and a copy of the front of the Janssen CarePath Patient Enrollment Form which they have signed.**

PATIENT AUTHORIZATION

My signature on the front of the Janssen CarePath Patient Enrollment Form confirms that I authorize each of my physicians, pharmacists, including any specialty pharmacy which receives my prescription for ZYTIGA® (abiraterone acetate) 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 and/or the person legally authorized to sign on my behalf, or the caregiver I have authorized to be contacted on my behalf by checking the box(es) in the Patient Authorization section on the front of this form about Janssen CarePath programs; (ii) provide me and/or the person legally authorized to sign on my behalf, or the caregiver I have authorized on my behalf by checking the box(es) in the Patient Authorization section on the front of this form with educational materials, information, and services related to ZYTIGA®; (iii) verify, investigate, assist with, and coordinate my coverage for ZYTIGA® with my Insurers; (iv) coordinate prescription fulfillment; and (v) assist with analyses related to the quality, efficacy, and safety of ZYTIGA®, and patient access to and adherence to ZYTIGA®. 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 Janssen CarePath Patient Enrollment 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 Janssen CarePath Patient Enrollment 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 Services. 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 59, 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.

Please read the Important Product Information for ZYTIGA® and discuss any questions you have with your doctor.

Janssen Biotech, Inc.

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