

Help your patients manage their Savings Program Benefits

- Submitting a rebate request to the J&J withMe Savings Program can be achieved in 2 ways:
 - the patient who is responsible can submit the rebate request, or
 - the patient may direct the provider to submit the rebate request on their behalf
- Please confirm with your patient who will submit the rebate requests to the Savings Program

NOTE: Rebate request must be submitted within 270 days of the date of service

The rebate payment is based on your patient's preferred payment method:

- To have your patient receive a **rebate by check**, submit a copy of their Explanation of Benefits (EOB) from their primary insurance provider (as well as any secondary insurance provider, if applicable) and a receipt from their treatment provider indicating proof of payment of their out-of-pocket medicine costs
- To have your patient receive the **rebate payment via their Virtual Payment Card**, submit a copy of only the patient's EOB from their primary insurance provider (as well as any secondary insurance provider, if applicable) indicating patient responsibility for their DARZALEX[®], DARZALEX FASPRO[®], TALVEY[®], or TECVAYLI[®] medicine costs

NOTE: Patients may also submit rebate requests to the Savings Program online at Account.JNJwithMe.com/submitrebate, by fax, or by mail

- To receive **payment directly on behalf of your patient**, you will need to submit a copy of their EOB from their primary insurance provider (as well as any secondary insurance provider, if applicable) indicating patient responsibility for their DARZALEX[®], DARZALEX FASPRO[®], TALVEY[®], or TECVAYLI[®] medicine costs, and either a CMS-1500 (HICF) or Uniform Billing Form—CMS-1450 (UB-04). A signed Patient Assignment of Benefits (AOB) must also be on file 48 hours prior to the rebate request

NOTE: Please ensure that your patient has completed an AOB form and that you have faxed the AOB form to the fax number found on the form, in order for J&J withMe to process a rebate claim and provide payment directly to your site. The AOB form can be found at Account.JNJwithMe.com or by calling J&J withMe at 833-JNJ-wMe1 (833-565-9631)

Submitting a primary claim:

To submit a **primary claim** on behalf of the patient, providers must submit a CMS-1500 (HICF) or Uniform Billing Form—CMS-1450 (UB-04)—**through their electronic billing system**.

Submitting a secondary claim—for payment to you by EFT or check:

- 1 If you have submitted a primary claim and the claim has a remaining balance of \$5 or more, you may submit a secondary claim.
 - Before you get started, contact your clearinghouse to request that Payer ID# 56155 be added to their system, if needed
- 2 Submit **secondary claim** to the J&J withMe Savings Program via the Provider Portal or fax (855-998-4422) using CMS-1500 or UB-04 medical claim forms or electronic versions 837P or 837I (electronic submission is preferred).
 - You will need to submit the primary payer EOB along with the secondary claim form
 - To complete the form, you will need the patient's J&J withMe Savings Program Member ID, Group# 00003716, and Payer ID# 56155
 - You will receive funds for approved claims by check, which will include information on setting up future payments via electronic funds transfer (EFT), if preferred
 - NOTE: If you already receive funds via EFT, you will continue to receive payments that way

See the following pages for sample CMS-1500 and UB-04 claim forms with additional information.

Please read full Prescribing Information for **DARZALEX**[®] and **DARZALEX FASPRO**[®]. Please read full Prescribing Information, including Boxed Warning, and Medication Guides for **TALVEY**[®] and **TECVAYLI**[®]. Provide the Medication Guide to your patients and encourage discussion.

Sample CMS-1500 Claim Form for Billing in the Physician Office

1

Insured's ID Number

Enter the J&J withMe
Savings Program Member
number

2

Insured's Name

Enter the patient's name,
even if the patient is not
the policyholder

3


Procedures, Services, or Supplies

Enter the NDC number in
the shaded area and enter
the appropriate J-Code,
S-Code, or G-Code

NOTE:

Fill out the remainder of the CMS-1500 claim form the same way you would for a typical secondary claim submission. Please make sure the claim documentation clearly states the CPT/J-Code or S-Code and the NDC and/or drug name. For payers that require the G-Codes, enter the applicable code based on the dose of DARZALEX®, DARZALEX FASPRO®, TALVEY®, or TECVAYLI®.

Use of the electronic version of the CMS-1500 (837P) is preferred.

HEALTH INSURANCE CLAIM FORM									
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12									
									
PICA <input type="checkbox"/> PICA <input type="checkbox"/>									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/>									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, John B.									
3. PATIENT'S BIRTH DATE MM DD YY 07 01 70									
4. INSURED'S NAME (Last Name, First Name, Middle Initial) Doe, John B.									
5. PATIENT'S ADDRESS (No., Street) 3914 Spruce Street									
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>									
7. INSURED'S ADDRESS (No., Street) 3914 Spruce Street									
CITY Anytown									
STATE AS									
ZIP CODE 01010									
TELEPHONE (Include Area Code) (203) 555-1234									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)									
10. IS PATIENT'S CONDITION RELATED TO:									
a. OTHER INSURED'S POLICY OR GROUP NUMBER									
a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO									
b. RESERVED FOR NUCC USE									
b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO									
c. RESERVED FOR NUCC USE									
c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO									
d. INSURANCE PLAN NAME OR PROGRAM NAME									
10d. CLAIM CODES (Designated by NUCC)									
11. INSURED'S POLICY GROUP OR FECA NUMBER									
a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>									
b. OTHER CLAIM ID (Designated by NUCC)									
c. INSURANCE PLAN NAME OR PROGRAM NAME									
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.									
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.									
SIGNED _____ DATE _____									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.									
15. OTHER DATE MM DD YY QUAL.									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Jones									
17a. NPI 123 456 7890									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) DARZALEX FASPRO®(daratumumab and hyaluronidase-fihj) 10 mg injection									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. <input type="checkbox"/>									
A. C34.30 B. C. L. D. E. F. G. H. I. J. K. L.									
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EFSOT (Family Plan) I. ID. QUAL. J. RENDERING PROVIDER ID. #									
1 04 01 24 04 01 24 11 57894-0503-01 J9144 A 180 NPI 123 456 7890									
2 04 01 24 04 01 24 11 96401 A 1 NPI 123 456 7890									
3									
4									
5									
6									
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>									
26. PATIENT'S ACCOUNT NO.									
27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO									
28. TOTAL CHARGE \$									
29. AMOUNT PAID \$									
30. Rsvd for NUCC Use									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)									
32. SERVICE FACILITY LOCATION INFORMATION									
33. BILLING PROVIDER INFO & PH # (203) 987-6543 Dr. Jones 4231 Center Road Anytown, AS 01010									
a. 123 456 7890 b.									

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

OMB APPROVAL PENDING

Sample UB-04 Claim Form for Billing in the Hospital Outpatient Department (HOPD)

1 Value Codes
Enter "PR2" under "Code" and enter the remaining patient responsibility after processing of the primary insurance claim under "Amount"

2 HCPCS/Rate/ HIPPS Code
Enter the appropriate J-Code, S-Code, or G-Code

3 Payer Name
Enter "J&J withMe Savings Program"

4 Health Plan ID
Enter the Group number: 00003716

5 Insured's Name
Enter the patient's name, even if the patient is not the policyholder

6 Insured's Unique ID
Enter the J&J withMe Savings Program Member number

NOTE:

Fill out the remainder of the UB-04 claim form the same way you would for a typical secondary claim submission. Please make sure the claim documentation clearly states the CPT/J-Code or S-Code and the NDC and/or drug name. For payers that require the G-Codes, enter the applicable code based on the dose of DARZALEX®, DARZALEX FASPRO®, TALVEY®, or TECVAYLI®.

Use of the electronic version of the UB-04 (837I) is preferred.

1 Anytown Hospital 160 Main Street Anytown, Anystate 01010										2 Pay-to-name Pay-to-address Pay-to-city/state										3a PAT. CNTL. # XX-XXXX b. MED. REC. # DOE1234-97 5 FED. TAX NO. 010001010										4 TYPE OF BILL																																																																																																																																																																																																							
8 PATIENT NAME a John B. Doe										9 PATIENT ADDRESS a 3914 Spruce Street										c AS d 01010 e US																																																																																																																																																																																																																	
10 BIRTHDATE 07-01-70										11 SEX M										12 DATE										13 HR										14 TYPE										15 SRC										16 DHR										17 STAT										18										19										20										21										22										23										24										25										26										27										28										29										30																													
31 OCCURRENCE DATE										32 CODE										33 OCCURRENCE DATE										34 CODE										35 OCCURRENCE DATE										36 CODE										37 OCCURRENCE DATE										38 CODE										39 VALUE CODES AMOUNT										40 VALUE CODES AMOUNT										41 VALUE CODES AMOUNT																																																																																																																																	
42 REV. CD.										43 DESCRIPTION										44 HCPCS / RATE / HIPPS CODE										45 SERV. DATE										46 SERV. UNITS										47 TOTAL CHARGES										48 NON-COVERED CHARGES										49																																																																																																																																																															
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J&J withMe is your single source for access, affordability, and treatment support programs from Johnson & Johnson. Your patients will be connected to the program that aligns with the J&J medicine they've been prescribed.

✓ **Access support**
to help navigate payer processes

✓ **Affordability support**
to help patients discover ways
to afford their J&J treatment

✓ **Dedicated 1-on-1
Care Connector**
to support the nonclinical
needs that may arise while
on their J&J medicine

**Convenient online Provider Portal
at Portal.JNJwithMe.com**

With an executed BAA or individual patient authorization on file, you can:

- Have access to a customizable patient dashboard with real-time status updates
- Initiate prior authorizations without benefits investigations
- Review the results of benefits investigations
- View or help manage Savings Program benefits on behalf of your patients
- Receive notifications when new information is available or action is required on the Portal



**Single, dedicated Care Connector
team supporting you and your patients**



Sign up or log in to the Provider Portal at
Portal.JNJwithMe.com



Visit us online at
JNJwithMe.com

Questions?



Call **833-JNJ-wMe1** (833-565-9631)
Monday–Friday, 8:00 AM–8:00 PM ET
Multilingual phone support available

Bookmark these links for quick and easy access!

The patient support and resources provided by J&J withMe are not intended to provide medical advice, replace a treatment plan from the patient's doctor or nurse, provide case management services, or serve as a reason to prescribe a J&J medicine.

Please read full Prescribing Information for **DARZALEX**[®] and **DARZALEX FASPRO**[®]. Please read full Prescribing Information, including Boxed Warning, and Medication Guides for **TALVEY**[®] and **TECVAYLI**[®]. Provide the Medication Guide to your patients and encourage discussion.