

Initiating a benefits investigation and connecting your patients to J&J withMe is easy



For prescribers

- ☐ Complete the required Prescriber Information and Prescription Information on pages 1-2
- ☐ If prior authorization assistance is NOT needed, check the appropriate box in the Prior Authorization section on page 3 to opt out



For patients/care partners

- ☐ Complete or have your patient complete the Patient Information and Insurance Information sections on page 1
- ☐ As requested by your patient, complete or have your patient complete the J&J withMe Savings Program section on page 3 to determine eligibility
- ☐ If you do not have a signed Business Associate Agreement (BAA) on file with us, have your patient read, sign, and date the Patient Authorization on pages 4-5
 - Give your patient a copy of the signed Patient Authorization Form and submit the original via fax or upload to the Provider Portal



Fax the completed and signed Benefits Investigation and Enrollment Form to J&J withMe at 855-998-4422. You can also request benefits investigations on the Provider Portal at Portal.JNJwithMe.com.

Here's what happens next



For prescribers

J&J withMe will:

- ✔ Confirm receipt of requests within 2 hours and verify benefits within 1 to 2 business days
- ✔ Provide you with a verification of benefits and call your patient to review the benefits

NOTE: J&J withMe cannot perform the benefits investigation without an executed Business Associate Agreement or Patient Authorization Form on file with us.



For patients/care partners

J&J withMe will:

- ✔ Call your patient to review the benefits and provide you with a verification of benefits
- ✔ Inform your patient about cost support options and offer your patient care coordination support services with the infusion provider or specialty pharmacy
- ✔ Enroll your eligible patient with commercial or private health insurance in the J&J withMe Savings Program, if requested by your patient



Need help?

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

Benefits Investigation
and Enrollment Form

J&J withMe cannot accept any information without an executed Business Associate Agreement or Patient Authorization Form, which can be found at Account.JNJwithMe.com/patientauth or as the last 2 pages of this document. The information you provide will be used by Johnson & Johnson Health Care Systems Inc., our affiliates, and our service providers for your patient's enrollment and participation in J&J withMe. Our **Privacy Policy** governs the use of the information you provide. By submitting this form, you indicate that you read, understand, and agree to these terms.

1. Patient Information (Required)

First Name _____ MI _____ Last Name _____
☐ Male ☐ Female Date of Birth (MM/DD/YYYY) _____ Preferred Language ☐ English ☐ Spanish ☐ Other
Address _____ City _____ State _____ ZIP _____
Patient Email _____ Patient Phone _____
Alternate Phone (Optional) _____ Best Time to Contact _____
Care Partner/Contact Name _____
(A care partner/contact is someone who can be contacted in place of the patient)
Care Partner/Contact Phone _____ Best Time to Contact _____
☐ I authorize J&J withMe to leave a message, including the name of the Johnson & Johnson medicine indicated on this form, if I am unavailable when they call.
☐ If I cannot be reached, I authorize J&J withMe to contact my care partner. ☐ I prefer and authorize J&J withMe to contact my care partner in place of me.
Please sign the Patient Authorization on pages 4-5.

2. Prescriber Information—to be completed by Physician (Required)

First Name _____ Last Name _____ Specialty _____
Practice Name _____ Office Contact Name _____
Address _____ City _____ State _____ ZIP _____
Email _____ Office Contact Phone _____ Fax _____
Medicaid/Medicare Provider # _____ Tax ID # _____
State License # _____ UPIN/NPI # _____ ICD-10 Diagnosis Code(s): _____

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 Johnson & Johnson Health Care Systems Inc. and its representatives to fax this prescription to: 1. The SP designated below, provided it is approved by this patient's plan. 2. If the SP designated is not a plan-approved SP, then to an 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.

Please check one:

☐ Preferred Specialty Pharmacy (ERLEADA® Only) _____ ☐ ONCO360 (AKEEGA® Only)
☐ Self-Dispensing Pharmacy (Please check this box if you are a self-dispensing pharmacy.) ☐ I do NOT wish to authorize prescription triage to SP.

3. Insurance Information (Required) Please provide information on insurance coverage for prescription drugs (pharmacy benefits).

Fields marked with an (*) are required

Primary Pharmacy Insurance _____ Phone _____
Card BIN # _____
Cardholder Name (First, MI, Last) _____ Relationship to Cardholder _____
Policy # _____ Group # _____ Fax _____
*Cardholder Employer Name _____ *Cardholder Employer Phone _____
*Address Line 1 _____ Address Line 2 _____
*City _____ *State _____ *ZIP _____

☐ Please investigate out-of-network benefits.

Please read full Prescribing Information for **AKEEGA®** and **ERLEADA®**.

J&J withMe cannot accept any information without an executed **Business Associate Agreement or Patient Authorization Form**, which can be found at Account.JNJwithMe.com/patientauth or as the last 2 pages of this document. The information you provide will be used by Johnson & Johnson Health Care Systems Inc., our affiliates, and our service providers for your patient's enrollment and participation in J&J withMe. Our [Privacy Policy](#) governs the use of the information you provide. By submitting this form, you indicate that you read, understand, and agree to these terms.

4. Patient Information (Required)

First Name _____ MI _____ Last Name _____
Date of Birth (MM/DD/YYYY) _____

5. Prescription Information—to be completed by Physician (Required)

Rx ERLEADA® ☐ 60 mg Tablets ☐ 240 mg Tablet

Directions: Take _____ mg PO _____ daily with or without food. Quantity _____ Refills # _____

Rx AKEEGA® ☐ 50 mg/500 mg Tablets ☐ 100 mg/500 mg Tablets

Directions: Take _____ mg / _____ mg PO _____ daily. Quantity _____ Refills # _____

Prescriber Name (if different from page 1) _____

Address _____

City _____ State _____ ZIP _____

Phone _____ Fax _____

PRESCRIBER SIGNATURE (NO STAMPS) REQUIRED. I certify that therapy with the Johnson & Johnson medicine indicated above is medically necessary for this patient. I will be supervising the patient's treatment accordingly, and I have reviewed the current full Prescribing Information for the Johnson & Johnson medicine indicated above. I authorize J&J withMe 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 _____

6. J&J withMe Savings Program (Optional)

Eligible patients using commercial insurance can save on out-of-pocket costs for their Johnson & Johnson medicine. See program requirements at [JNJwithMe.com](https://www.jnjwithme.com).

- ☐ I would like J&J withMe to check the patient's eligibility for and enroll the patient into the J&J withMe Savings Program if the results of this benefits investigation determine that the patient has commercial or private health insurance.

7. J&J withMe Care Navigator Support (Optional)

All eligible patients will be contacted by J&J withMe for access to a Care Navigator. You may opt out by checking the box below.

J&J withMe is a free, personalized patient support program that offers patients access to a dedicated Care Navigator who will provide one-on-one guidance over the phone. J&J withMe will contact the patient within 1 business day unless you select the check box below to opt your patient out. If you would like to speak with a Care Navigator immediately, please call 833-JNJ-wMe1 (833-565-9631), Monday–Friday, 8:30 AM–8:30 PM ET. A signed Patient Authorization Form is required to receive Care Navigator support.

- ☐ I would **NOT** like my patient to be contacted by J&J withMe to learn how a Care Navigator may be able to provide additional education and support.

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.

8. Prior Authorization—to be completed by Physician (Optional)

Automatically provided with benefits investigation. You may opt out by checking the box below.

Prior Authorization Form Assistance and Status Monitoring: J&J withMe assists your office in providing the requirements of the patient's health plan related to prior authorization for treatment with the medicine specified on this form. 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, if received from the health plan, will be provided to your office for possible completion and submission in the office's sole discretion. J&J withMe 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 the medicine specified on this form.

- ☐ I do **NOT** wish to receive Prior Authorization Form Assistance or Status Monitoring. This opt-out does not apply when the patient is signed up to receive the product at no cost until their insurance covers the medicine if delayed >5 days or denied.

Information about your patient's insurance coverage, cost support options, and treatment support is given by service providers for J&J withMe. The information you get does not require you or your patient to use any J&J product. Because the information we give you comes from outside sources, J&J withMe cannot promise the information will be complete.

Please read full Prescribing Information for **AKEEGA®** and **ERLEADA®**.


Why should I sign this Form?

This Form gives your Healthcare Providers permission to use and share your medical information with the patient support programs offered by Johnson & Johnson.

Section 1 What health information am I sharing and with whom?

I give permission for my Healthcare Providers and Insurers (eg, my health insurance plans) to share my Protected Health Information, as described on this Form.

 **My Protected Health Information includes information related to:** my medical condition, treatment, prescriptions, and health insurance coverage

 **My Healthcare Providers may include:** physicians, pharmacists, specialty pharmacies, other healthcare providers, and staff members at my healthcare providers' offices

I give permission to these people or groups to receive and use my Protected Health Information (collectively "J&J"):

- Johnson & Johnson Health Care Systems Inc., its affiliated companies, agents, and representatives
- Service providers for the patient support programs. This includes subcontractors or healthcare providers helping J&J run the programs
- Providers of other sources of funding. This includes foundations and co-pay assistance providers
- Service providers maintaining, transmitting, de-identifying, aggregating, or analyzing data from J&J's support programs

 **My Protected Health Information may be shared by J&J with these people and groups:** my Insurers, my Healthcare Providers, any other people given permission to receive and use my Protected Health Information (as mentioned above), anyone I give permission to as an additional contact, and service providers who review data from J&J's patient support programs

 **J&J and the other groups on this Form may share information about me in 2 ways:** as permitted on this Form, and if any information that identifies me is removed from what has been shared

Section 2 How can giving permission help with patient support programs and access?

I give permission to J&J to receive, use, and share my Protected Health Information to:

- See if I qualify for, sign me up for, contact me about, and provide services relating to J&J's patient support programs. This includes in-home services
- Manage J&J's patient support programs
- Give me resources and information related to my J&J medicine in connection with J&J's patient support programs. This includes educational and adherence materials
- Communicate with my Healthcare Providers about access, reimbursement, and fulfillment for my J&J medicine
- Inform my Healthcare Provider that I am enrolled in J&J's patient support programs
- Help verify and coordinate coverage for J&J medicines with my Insurers and Healthcare Providers
- Help with prescription or treatment location and associated scheduling
- Conduct analysis to help J&J evaluate, create, and improve their patient support services and products for patients prescribed J&J medicines
- Share information from J&J's patient support programs that may be useful for my care

Section 3 What should I understand before signing this Form?

I understand that:

- ☐ J&J will use reasonable efforts to keep my information private. But, once my Protected Health Information is disclosed as allowed on this Form, it may no longer be protected by federal privacy laws
- ☒ I am not required to sign this Form. My choice about whether to sign will not change how my Healthcare Providers or Insurers treat me. If I do not sign this Form, or cancel or remove my permission later, I understand I will not be able to participate in or receive assistance from J&J's patient support programs
- ☐ The following groups may be paid by J&J for their services and data, including Protected Health Information:
 - Pharmacies that dispense and ship my medicine
 - Service providers for J&J's patient support programs
- ☐ This Form will remain in effect 10 years from the date I signed below, except if:
 - State law requires a shorter time or
 - I am no longer in any patient support program from J&J
- ☒ Information collected before that date may continue to be used for the purposes noted in this Form
 - I may cancel the permissions given by this Form at any time by letting J&J know in writing at: J&J withMe, 2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560
 - I can also cancel my permission by letting my Healthcare Providers and Insurers know in writing that I do not want them to share any information with J&J
 - If I cancel my permission, it will not affect how J&J uses and shares my Protected Health Information received by J&J before my cancellation
 - I may request a copy of this Form

For privacy rights and choices specific to California, Colorado, Connecticut, Utah, Virginia, and Washington residents, please see J&J's US Supplemental Privacy Notice available at <https://www.janssen.com/us/privacy-policy#supplemental>

Section 4 Fill in Personal Information & Sign Patient Authorization Form

Patient name (print): _____ Email Address: _____

Patient sign here: _____ Date: _____

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

By: _____ Print name: _____ Date: _____

(Signature of person legally authorized to sign for patient)

Describe relationship to patient and authority to make medical decisions for patient:

Optional Resources

Permission for communications outside of J&J's patient support programs:

- ☐ Yes, I would like to receive communications about my J&J medicine
- ☐ Yes, I would like to receive communications about other products and services from J&J

Permission for text communications:

- ☐ Yes, I would like to receive text messages. By selecting this option, I agree to receive text messages as allowed by this Form to the cell phone number provided below. Message and data rates may apply. Message frequency varies. I understand I am not required to provide my permission to receive text messages to participate in J&J's patient support programs or to receive any other communications I have selected. Cell phone number: _____



Sign and return this Form to:

Fax to: 844-286-5444
 J&J withMe
2250 Perimeter Park Drive, Suite 300
Morrisville, NC 27560

Or, eSign a digital Form:

In your healthcare provider's office
 At Account.JNJwithMe.com