J&J withMe

DARZALEX® (daratumumab) injection for intravenous infusion 100 mg/5 mL, 400 mg/20 mL

DARZALEX Faspro® (daratumumab and hyaluronidase-fihj) Injection for subcutaneous use | 1,800mg/30,000units

TALVEY® (talquetamab-tgvs) Injection for subcutaneous use 2 mg/mL and 40 mg/mL

TECVAYLI® (teclistamab-cqyv) Injection for subcutaneous use 10 mg/mL and 90 mg/mL

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
- ☐ Complete the required Treatment Location Information section on page 3
- ☐ If prior authorization assistance is NOT needed, check the appropriate box in the Prior Authorization section on page 4 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 4 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 5-6
  - 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

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.

J&J withMe

UPDATE 09.24

Benefits Investigation and Enrollment Form

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TECVAYLI® (teclistamab-cqyv)

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 5-6.

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): _____

3. Insurance Information (Complete for all available insurance and submit copies of front and back of all insurance cards)

Fields marked with an (*) are required

Primary Medical Insurance _____ Phone _____

Cardholder Name (First, MI, Last) _____ Relationship to Cardholder _____

Policy # _____ Group # _____ Fax _____

Secondary Medical Insurance _____ Phone: _____

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 **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.

J&J withMe

Benefits Investigation and Enrollment Form

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4. Patient Information (Required)

First Name _____ MI _____ Last Name _____

Date of Birth (MM/DD/YYYY) _____

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

Medication

☐ DARZALEX® (daratumumab) ☐ DARZALEX *FASPRO*® (daratumumab and hyaluronidase-fihj) ☐ TALVEY® (talquetamab-tgvs) ☐ TECVAYLI® (teclistamab-cqyv)

Treatment Information (If prescribing TALVEY® or TECVAYLI®, skip to section below)

Dosage Form and Strength _____ No. of Vials _____

Administration _____

Patient Weight _____ lb _____ kg

Has the patient started therapy with the medication specified above? ☐ Yes ☐ No If yes, what date did the patient start therapy? (MM/DD/YYYY) _____

Additional information regarding treatment (if applicable to benefits verification) _____

DARZALEX® and DARZALEX *FASPRO*® only:

☐ Monotherapy ☐ Combination Therapy

If Combination, list medications: _____

Prior Medications/Treatments: _____

TALVEY® only:

Patient Weight _____ lb _____ kg

Has the patient received at least four prior lines of therapy, including a proteasome inhibitor, an immunomodulatory agent, and an anti-CD38 monoclonal antibody? ☐ Yes ☐ No

Weekly Dosing:

☐ **Step-Up Dosing**
- ☐ Step-Up Dose 1 (0.01 mg/kg): 3 mg/1.5 mL single-dose vial
- ☐ Step-Up Dose 2 (0.06 mg/kg): 3 mg/1.5 mL single-dose vial No. of Vials _____
- ☐ First Treatment Dose (0.4 mg/kg): 40 mg/mL single-dose vial No. of Vials _____

☐ **Weekly Dosing**
- ☐ Subsequent Treatment Doses (0.4 mg/kg): 40 mg/mL single-dose vial
  No. of Vials _____

Biweekly (Every 2 Weeks) Dosing:

☐ **Step-Up Dosing**
- ☐ Step-Up Dose 1 (0.01 mg/kg): 3 mg/1.5 mL single-dose vial
- ☐ Step-Up Dose 2 (0.06 mg/kg): 3 mg/1.5 mL single-dose vial No. of Vials _____
- ☐ Step-Up Dose 3 (0.4 mg/kg): 40 mg/mL single-dose vial No. of Vials _____
- ☐ First Treatment Dose (0.8 mg/kg): 40 mg/mL single-dose vial No. of Vials _____

☐ **Biweekly (Every 2 Weeks) Dosing**
- ☐ Subsequent Treatment Doses (0.8 mg/kg): 40 mg/mL single-dose vial No. of Vials _____

TECVAYLI® only:

Patient Weight _____ lb _____ kg

Has the patient received at least four prior lines of therapy, including a proteasome inhibitor, an immunomodulatory agent, and an anti-CD38 monoclonal antibody? ☐ Yes ☐ No

Recommended Dosing:

☐ **Step-Up Dosing**
- ☐ Step-Up Dose 1 (0.06 mg/kg): 30 mg/3 mL (10 mg/mL) single-dose vial
- ☐ Step-Up Dose 2 (0.3 mg/kg): 30 mg/3 mL (10 mg/mL) single-dose vial No. of Vials _____
- ☐ First Treatment Dose (1.5 mg/kg): 153 mg/1.7 mL (90 mg/mL) single-dose vial No. of Vials _____

☐ **Weekly Dosing**
- ☐ Subsequent Treatment Doses (1.5 mg/kg): 153 mg/1.7 mL (90 mg/mL) single-dose vial
  No. of Vials _____

While receiving TECVAYLI®, has the patient achieved and maintained a complete response or better for a minimum of 6 months? ☐ Yes ☐ No

If yes, the following dosing frequency decrease may be considered:

☐ **Biweekly (Every 2 Weeks) Dosing**
- ☐ Subsequent Treatment Doses (1.5 mg/kg): 153 mg/1.7 mL (90 mg/mL) single-dose vial No. of Vials _____

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 _____

Supervising Physician Signature (If applicable) _____ Date _____

Supervising Physician Name _____

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.

J&J withMe

Benefits Investigation and Enrollment Form

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6a. Treatment Location—to be completed by Physician (Required)

Dosage Type (Required for TALVEY® and TECVAYLI® only)

☐ Step-Up Phase ☐ Treatment Phase

Treatment Location Type (If additional treatment location is needed, please complete section 6b below)

☐ Prescribing MD's Office ☐ Non-prescribing MD's Office ☐ Home Infusion/Infusion Provider Company

☐ Hospital Outpatient ☐ Hospital Inpatient ☐ Other _____

Provider Information

If prescribing MD's office, the fields below do not need to be completed if information is the same as the Prescriber Information section.

Provider First Name _____ Provider Last Name _____ Physician Specialty _____

Practice Name _____

Address _____

City _____ State _____ ZIP _____

Site Phone _____ Site Fax _____

Insurance Provider # _____ Tax ID # _____

6b. Additional Treatment Location—to be completed by Physician (Required for TALVEY® and TECVAYLI® if patient will be treated at more than one location)

Dosage Type (Required)

☐ Step-Up Phase ☐ Treatment Phase

Treatment Location Type

☐ Prescribing MD's Office ☐ Non-prescribing MD's Office ☐ Home Infusion/Infusion Provider Company

☐ Hospital Outpatient ☐ Hospital Inpatient ☐ Other _____

Provider Information

If prescribing MD's office, the fields below do not need to be completed if information is the same as the Prescriber Information section.

Provider First Name _____ Provider Last Name _____ Physician Specialty _____

Practice Name _____

Address _____

City _____ State _____ ZIP _____

Site Phone _____ Site Fax _____

Insurance Provider # _____ Tax ID # _____

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TALVEY® (talquetamab-tgvs)
TECVAYLI® (teclistamab-cqyv)

7. 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.

☐ 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.

8. 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.

9. 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 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.

Johnson & Johnson

Patient support program
Patient authorization form

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
- Providers of other sources of funding. This includes foundations and co-pay assistance providers
- Service providers for the patient support programs. This includes subcontractors or healthcare providers helping J&J run the programs
- 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**

