1. **OPTIONAL:** This form is optional. Signing this form is **not** required for a patient to receive medical treatment, to start or stay on therapy, or to be enrolled in the J&J withMe Savings Program.
2. **AUTHORIZATION:** By signing this form, the patient authorizes J&J withMe Savings Program to issue payment directly to their provider for any reimbursement amounts attributable to the costs of medicine administered in their provider’s office. This form grants patient authorization for **all** of the patient’s treatment providers who submit a rebate request to the J&J withMe Savings Program.
3. **INSTRUCTIONS:** Patient must read this form, complete all fields, sign, and upload the form to their Patient Account at [**Account.JNJwithMe.com**](https://www.myjanssencarepath.com/). Providers may also upload the completed form to the Provider Portal **(**[**Portal.JNJWithMe.com**](https://www.janssencarepathportal.com/s/login/SelfRegister)**)**.
4. **CANCELLATION:** Patient may, at any time, call J&J withMe at 833-JNJ-wMe1 (833-565-9631)
and cancel their Assignment of Benefits.

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| **Patient Authorization** |
| The information you provide will be used by Johnson & Johnson Health Care Systems Inc., our affiliates, and our service providers (“J&J withMe”) to perform services related to J&J withMe. Our [**Privacy Policy**](https://www.myjanssencarepath.com/s/privacypolicy) further governs the use of information you provide. By providing the information and signing below, you indicate that you read, understand, and agree with these terms. You also understand that you may, at any time, call J&J withMe and cancel this Assignment of Benefits. Upon cancellation, payment will no longer be sent directly to your provider(s) and will be sent to you or loaded to your J&J withMe Savings Program card. |  |
| Patient: Name: |       | Date of Birth (mm/dd/yyyy): |       |  |
| J&J withMe Savings Program Member # (OPTIONAL): |       |  |
| (from Savings Program card) |  |
|  |  |
| Patient: Address: |       |  |
| City:  |       | State:  |    | ZIP: Code:  |       |  |
| **Patient Signature:** |  | Date:  |       |  |
| If the patient cannot sign, patient’s legally authorized representative must sign below. |
| By: |  | Date:  |       |  |
| (Signature of person legally authorized to sign for patient) |
| Describe relationship to patient and authority to make medical decisions for patient: |  |  |
|  |       |  |
|  |