janssen CarePath UPDATE 05.24

Gastroenterologist Patient Enrollment Form

Remicade® INFLIXIMAB | Infliximab | Simponi® golimumab

Complete and fax this Form to 855-224-5072 or mail to PO Box 15510, Pittsburgh, PA 15244.
For assistance, call 877-CarePath (877-227-3728), Monday–Friday, 8:00 AM–8:00 PM ET.
A completed Patient Authorization Form, found on pages 3 and 4 of this document, is necessary to access certain patient support under Janssen CarePath. Please submit the Patient Authorization Form with this completed Patient Enrollment Form.
The information you provide will be used by a pharmacy affiliated with Janssen Biotech, Inc., and its service providers (Pharmacy) in connection with your patient's treatment. The information you provide will be used in accordance with **The Notice of Privacy Practices** ("Privacy Policy").

Comprehensive support to help your patients start and stay on prescribed treatment

We will verify insurance coverage, support and monitor the prior authorization process, provide reimbursement information, help find affordability options for eligible patients, and provide ongoing support to help patients stay on Janssen medications. This includes:

Delay and Denial Support: Janssen offers eligible patients SIMPONI® at no cost until their commercial insurance covers the medication. To enroll your patient in Delay and Denial Support, a SIMPONI® Prescription via Janssen CarePath must be completed in section 5.

Janssen Patient Assistance Program: Patient assistance is available if your patient has commercial, employer-sponsored, or government coverage that does not fully meet their needs. Your patient may be eligible to receive their Janssen medication free of charge for up to one year if they meet the eligibility and income requirements for the Janssen Patient Assistance Program. To enroll your patient in the Janssen Patient Assistance Program, a SIMPONI®, REMICADE® or Infliximab Prescription via Janssen CarePath is required in section 5.

1. PATIENT INFORMATION (REQUIRED)

NAME (First, MI, Last) ______ SEX ☐ M ☐ F
DOB (MM/DD/YYYY) ______ ADDRESS ______
CITY ______ STATE ______ ZIP CODE ______ E-MAIL ______
CELL PHONE ______ HOME PHONE ______ WORK PHONE ______
PREFERRED NUMBER TO CALL ☐ Cell ☐ Home ☐ Work BEST TIME TO CONTACT ☐ Morning ☐ Afternoon ☐ Evening
☐ The patient has consented to treatment by the Pharmacy and has authorized the collection, use, and disclosure of their health information as described in the Privacy Policy. I understand that the Pharmacy may be contacting the patient by phone or otherwise concerning this program.

2. INSURANCE INFORMATION (REQUIRED. Complete fields below OR provide a copy of insurance cards.)

PRIMARY INSURANCE ______ CARDHOLDER ______
RELATIONSHIP TO CARDHOLDER ______ EMPLOYER ______ INS. CO. PHONE ______
POLICY # ______ GROUP # ______
SECONDARY INSURANCE ______ CARDHOLDER ______
RELATIONSHIP TO CARDHOLDER ______ EMPLOYER ______ INS. CO. PHONE ______
POLICY # ______ GROUP # ______
PRESCRIPTION DRUG INSURER ______ CARD/BIN # ______ PHONE ______
☐ Is patient a dependent of the insured (child <18 years; student >18 years)? Check if yes.
☐ **PLEASE INVESTIGATE OUT-OF-NETWORK BENEFITS FOR REMICADE® or Infliximab**
NOTE: For SIMPONI®, pharmacy benefit will be investigated. If patient does not have a pharmacy benefit, medical benefits will be investigated.

3. PRIOR MEDICATIONS (REQUIRED. Specify—P=Prior, C=Current, F=Failure)

☐ 5-ASA ______ ☐ Azathioprine ______ ☐ Cimzia® ______ ☐ Cyclosporine ______ ☐ Methotrexate ______
☐ 6-MP ______ ☐ Azulfidine® ______ ☐ Corticosteroids ______ ☐ Humira® ______ ☐ Other ______

ADDITIONAL CLINICAL INFORMATION

DATE OF DIAGNOSIS OR YEARS WITH DISEASE ______ PATIENT WEIGHT ______ lb ______ kg
PREVIOUS TB TEST (DATE) ______ HEPATITIS B VIRUS TEST (DATE) ______ SCHEDULED DATE OF INFUSION ______

4. PRESCRIBER INFORMATION (REQUIRED)

PRESCRIBER NAME (First, Last) ______
SPECIALTY ______
PRACTICE NAME ______ OFFICE CONTACT ______
ADDRESS ______
CITY ______ STATE ______ ZIP CODE ______
E-MAIL ______ PHONE ______ FAX ______
MEDICAID/MEDICARE PROVIDER # ______ TAX ID # ______
STATE LICENSE # ______ UPIN/NPI # ______
Are you the prescribing specialist? (Required) ☐ YES ☐ NO: IF NO, REFERRING SPECIALIST ______
REFERRING PHYSICIAN SPECIALTY ______

5. PRESCRIPTION (REQUIRED): Please complete if requesting a benefits investigation even if not prescribing. Visit JanssenCarePath.com for ICD-10 codes or consult the ICD-10 code book for additional information)

☐ **REMICADE® or** ☐ **Infliximab DIAGNOSIS: Crohn's Disease, Fistula (Secondary to Crohn's Disease), Ulcerative Colitis**
DIAGNOSIS CODE ______ INDICATION ______
☐ **INDUCTION:** Infuse ______ mg IV at weeks 0, 2, 6 Vials # (for 1 infusion) ______ Refills: 2
☐ **MAINTENANCE:** Infuse ______ mg IV every ______ weeks thereafter Vials # (for 1 infusion) ______ Refills # ______

☐ **SIMPONI® DIAGNOSIS: Ulcerative Colitis**
DIAGNOSIS CODE ______ INDICATION ______
DIRECTIONS: **STARTER DOSES:**
☐ 200 mg at Week 0; 2 single-use autoinjectors, 100 mg/1.0 mL SC
☐ 200 mg at Week 0; 2 single-use prefilled syringes, 100 mg/1.0 mL SC
☐ 100 mg at Week 2; 1 single-use autoinjector, 100 mg/1.0 mL SC
☐ 100 mg at Week 2; 1 single-use prefilled syringe, 100 mg/1.0 mL SC
MAINTENANCE THERAPY:
☐ 1 single-use autoinjector, 100 mg/1.0 mL SC every 4 weeks ☐ 1 single-use prefilled syringe, 100 mg/1.0 mL SC every 4 weeks Refills # ______
☐ OTHER ______ Refills # ______

SIMPONI®, REMICADE® or Infliximab Prescription

Signature required to enroll eligible patients in Delay and Denial Support or Janssen Patient Assistance Program.

PRESCRIBER SIGNATURE ☐ Dispense as Written ______ DATE ______

By submitting this prescription, I understand the Pharmacy will check the patient's eligibility for and may enroll the patient in certain support programs based on the results of the benefits investigation with patient consent. If the patient is eligible for support programs, I certify that I agree to the program's requirements and will take the necessary actions described in the requirements for the patient. See program requirement on page 2.

Commercial Pharmacy Prescription (OPTIONAL)

Patient or Provider preferred pharmacy ______
PRESCRIBER SIGNATURE ☐ Dispense as Written ______ DATE ______

PRESCRIBER SIGNATURE (NO STAMPS ALLOWED) REQUIRED TO VALIDATE PRESCRIPTION: I certify that therapy with SIMPONI® is medically necessary for this patient. I will be supervising the patient's treatment accordingly, and I have reviewed the current SIMPONI®, REMICADE®, and Infliximab Prescribing Information.

6. REMICADE® or Infliximab PREFERRED SITE OF INFUSION (REQUIRED)

(Fields below do not need to be completed if information is the same as in the Prescriber Information section)

☐ Prescribing MD's office ☐ Non-prescribing MD's office ☐ Hospital outpatient ☐ Home infusion/Infusion Provider Company ☐ Other
PHYSICIAN OR INFUSION PROVIDER NAME ______
PRACTICE/FACILITY NAME ______
ADDRESS ______
CITY ______ STATE ______ ZIP CODE ______
PHONE ______ FAX ______ CONTACT NAME ______
INSURANCE PROVIDER # ______ TAX ID # ______

7. SHIPPING INFORMATION FOR SIMPONI® (REQUIRED to complete benefits investigation even if not prescribing. NOTE: Shipments cannot be sent to P.O. Boxes)

SHIP TO: ☐ PROVIDER OFFICE—Initial injection only
☐ PATIENT'S HOME—I have instructed the patient in proper injection technique for SIMPONI® and the patient will self-administer ☐ OTHER
NAME (if different than above) ______
ADDRESS ______ CITY ______ STATE ______
ZIP CODE ______ PHONE ______ FAX ______

8. PREFERRED SPECIALTY 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.

☐ Accredo ☐ Amber ☐ BioPlus ☐ BriovaRx ☐ CVS Caremark ☐ Cigna ☐ Diplomat ☐ Humana
☐ Kroger ☐ Senderra ☐ AllianceRx ☐ Other ______

Please see full Prescribing Information, including Boxed Warnings, and Medication Guides for REMICADE® and Infliximab, and SIMPONI®.

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

DELAY AND DENIAL SUPPORT

Janssen offers eligible patients SIMPONI® (golimumab) at no cost until their commercial insurance covers the medication. See program requirements below.

To be eligible, patient must have:

1. a SIMPONI® prescription for an on-label, FDA-approved indication.
2. commercial insurance with biologics coverage.
3. a delay of more than 5 business days or a denial of treatment from their insurance.

In addition, for patient to be eligible, Prescriber must submit:

4. a coverage determination form (ie, prior authorization or prior authorization with exception) to the commercial insurance. If coverage is denied, Prescriber must also submit a Letter of Formulary Exception, Letter of Medical Necessity, or appeal within 90 days of patient becoming eligible for patient to stay in the program.

Patient is not eligible if:

1. patient uses any state or federal government-funded healthcare program to cover medication costs. Examples of these programs are Medicare, Medicaid, TRICARE, Department of Defense, and Veterans Administration.
2. prior authorization is denied due to missing information on coverage determination form, use for a non-FDA-approved indication, or invalid clinical rationale.

Patient is eligible until commercial insurance covers the medication. Program requires periodic verification of insurance coverage status to confirm continued eligibility.

Delay and Denial Support covers the cost of therapy only—not associated administration cost. Prescriber cannot bill commercial insurance plan for any part of the prescribed subcutaneous treatment. Patient cannot submit the value of the free product as a claim for payment to any health plan. Program good only in the United States and its territories. Void where prohibited, taxed, or limited by law. Program terms may change.

JANSSEN PATIENT ASSISTANCE PROGRAM

Your patient may be eligible to receive their Janssen medication(s) free of charge for up to one year if they have been prescribed a Janssen medication, have a financial hardship, and are currently enrolled in government, commercial, or employer group health insurance.

Your patient must meet the eligibility and income requirements to qualify for the patient assistance program.

Your patient is not eligible for free Janssen medication if their health insurance will cover the cost of their Janssen-prescribed medication if this application is denied. Some employers, insurers, and other companies force patients to apply for medically necessary medications from free product programs instead of covering such medications directly and immediately through insurance, which could lead to delays in care and discriminate against lower-income patients. These types of "Assistance Diversion Programs" are generally established by companies that profit by diverting resources away from patients in need. An Assistance Diversion Program is any insurer, employer, or third-party program that withholds coverage or payment for Patient's medically necessary drug until Patient has completed an application for free product assistance. Assistance Diversion Programs are prohibited by Janssen to make sure that help is available for patients with no safety net in place. Your patient's insurer must submit a Patient Eligibility Certification form to confirm that their drug coverage is not subject to an Assistance Diversion Program.

Your patient may not seek payment for the value of Janssen medications received from this program from any health plan, patient assistance foundation, flexible spending account, or healthcare savings account.

Before your patient enrolls in the patient assistance program, it is important they understand that they will be asked to provide personal information that may include their name, address, phone number, email address, financial information, and information related to their prescription medication insurance and treatment. This information will be used by Janssen Biotech, Inc., and its service providers to determine their eligibility for, enroll them in, and administer the program. The information will also be used to learn more about the people who use the program, to improve the program, and will be shared with service providers supporting the program.

If your patient has Medicare Prescription Drug Coverage (Part D) they may be asked to attest to or submit a report from their pharmacy or an Explanation of Benefits (EOB) statement from their insurer that shows their out-of-pocket costs for the current year. To qualify for the program, 4% of the patient's gross annual household income must be spent on out-of-pocket prescription expenses for the patient and/or other members of their household.

This program offer may not be used with any other coupon, discount, prescription savings card, free trial, or other offer. Offer good only in the United States and its territories. Void where prohibited, taxed, or limited by law. Program terms will expire at the end of each calendar year and may change or end without notice, including in specific states.

Your patient may end their participation in the program at any time by calling 877-CarePath (877-227-3728), Monday through Friday, 8:00 AM to 8:00 PM ET.

Please see full Prescribing Information, including Boxed Warning, and Medication Guide for SIMPONI®.

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Janssen PHARMACEUTICAL COMPANIES OF Johnson & Johnson

Janssen Patient Support Program Patient Authorization Form

Patients should read the Patient Authorization, check the desired permission boxes, and return both pages of the Form to Janssen Patient Support Program.

- **Download a copy, print, check the desired boxes, and sign. Your healthcare provider may scan the completed Form and upload on Provider Portal, or completed Form may be faxed to 855-224-5072 or mailed to Janssen CarePath, PO Box 15510, Pittsburgh, PA 15244**
- **You may be able to eSign a digital Form in your healthcare provider's office or on the Janssen CarePath Patient Account at MyJanssenCarePath.com**

Patient Name: ______________________________ **Email Address:** ______________________________

I give permission for each of my "Healthcare Providers" (eg, my physicians, pharmacists, specialty pharmacies, other healthcare providers, and their staff) and "Insurers" (eg, my health insurance plans) to share my Protected Health Information as described on this Form.

My "Protected Health Information" includes any and all information related to my medical condition, treatment, prescriptions, and health insurance coverage.

The following person(s) or class of person(s) are given permission to receive and use my Protected Health Information (collectively "Janssen"):

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

Also, I give permission to Janssen to receive, use, and share my Protected Health Information in order to:

- see if I qualify for, sign me up for, contact me about, and provide services relating to Janssen patient support programs, including in-home services
- manage the Janssen patient support programs
- give me educational and adherence materials, information, and resources related to my Janssen medication in connection with Janssen patient support programs
- communicate with my Healthcare Providers regarding access to, reimbursement for, and fulfillment of my Janssen medication, and to tell my Healthcare Provider that I am participating in Janssen patient support programs
- verify, assist with, and coordinate my coverage for my Janssen medication with my Insurers and Healthcare Providers
- coordinate prescription or treatment location and associated scheduling
- conduct analysis to help Janssen evaluate, create, and improve its products, services, and customer support for patients prescribed Janssen medications
- share and give access to information created by the Janssen patient support programs that may be useful for my care

I understand that my Protected Health Information may be shared by Janssen for the uses written in this Form to:

- My Insurers
- My Healthcare Providers
- Any of the persons given permission to receive and use my Protected Health Information as mentioned above
- Any individual I give permission as an additional contact

Janssen and the other data recipients listed on this Form may share information about me as permitted on this Form or if any information that specifically identifies me is removed. I understand that Janssen 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 understand that 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.

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Janssen Patient Support Program Patient Authorization Form

If I do not sign this Form, or cancel or remove my permission later, I understand I will not be able to participate or receive assistance from Janssen's patient support programs.

I understand that pharmacies that dispense and ship my medication and service providers for the patient support programs may be paid by Janssen for their services and data. This may include payment for sharing Protected Health Information and other data in connection with these programs, as allowed on this Form.

This Form will remain in effect 10 years from the date of signature, except where state law requires a shorter time, or until I am no longer participating in any Janssen patient support programs. Information collected before that date may continue to be used for the purposes set forth in this Form.

I understand that I may cancel the permissions given by this Form at any time by letting Janssen know in writing at: Janssen CarePath, PO Box 15510, Pittsburgh, PA 15244.

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 Janssen.

I further understand that if I cancel my permission it will not affect how Janssen uses and shares my Protected Health Information received by Janssen prior to my cancellation.

I understand I may request a copy of this Form.

Permission for communications outside of Janssen patient support programs:

- ☐ Yes, I would like to receive communications relating to my Janssen medication.
- ☐ Yes, I would like to receive communications relating to other Janssen products and services.

For privacy rights and choices specific to California residents, please see Janssen's California privacy notice available at **https://www.janssen.com/us/privacy-policy#california**

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 the Janssen patient support programs or to receive any other communications I have selected.

  Cell phone number: ______________________

Patient name (print): ______________________

Patient sign here: ______________________ **Date:** ______________________

If the 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:

____

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