Tremfya withMe | Tremfya® (guselkumab)

Gastroenterology Patient Enrollment Form

UPDATE 03.25

Complete and fax this form to 800-600-7226. All fields are required unless marked optional.

For assistance, prescribers can call 844-4withMe (844-494-8463), 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 TREMFYA withMe. Please have your patient sign the Patient Authorization Form and submit with this completed Patient Enrollment Form. The information you provide will be processed by Johnson & Johnson Health Care Systems Inc. and its service providers in accordance with its **Privacy Policy**, and, if applicable, its affiliated, noncommercial dispensing pharmacy, Access Therapy Center ("Pharmacy"), in accordance with its **Notice of Privacy Practices**.

1. Patient Information — TO BE COMPLETED BY PATIENT AND PROVIDER

NAME (First, M, Last) _____ DOB (MM/DD/YYYY) _____ SEX ☐ M ☐ F

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

PHONE _____ EMAIL ADDRESS (optional) _____

☐ **The patient has consented to treatment by the Pharmacy, if eligible, 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 — TO BE COMPLETED BY PATIENT AND PROVIDER

Provide a copy of the front and back of insurance card(s). (If providing copy of insurance card(s), skip to section 3. Clinical Information.) ☐ **The patient has no insurance and has checked eligibility requirements or applied to all available options for free or minimal cost insurance or other assistance. If the patient was previously enrolled in a patient assistance program, please provide the patient ID #:** _____

Medical Insurance _____ POLICY# _____ GROUP# _____

CARDHOLDER _____

Pharmacy Insurance _____ PCN# _____ GrpRX# _____

CARDHOLDER _____ POLICY# _____ CARD/BIN# _____

▼ TO BE COMPLETED BY PROVIDER ▼

3. Clinical Information

TREMFYA®—DIAGNOSIS SELECT ONE: ☐ K51.90 Ulcerative Colitis, Unspecified ☐ K50.90 Crohn's Disease, Unspecified ☐ Other ICD-10 Code _____

TREATMENT START DATE (MM/DD/YYYY): _____ ☐ Not yet started. If not yet started, estimated start date (MM/DD/YYYY): _____

PRIOR MEDICINES (optional) _____

4. Prescriber Information

PRESCRIBER NAME (First, Last) _____

OFFICE CONTACT (optional) _____ PTAN (Medicare patients only) _____

PRACTICE NAME _____ NPI# _____ TAX ID# (optional) _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

EMAIL _____ PHONE _____ FAX _____

5. Prescription Information (Required to complete benefits investigation.)

STEP 1: Complete induction information for either Subcutaneous or Intravenous Induction only

SUBCUTANEOUS INDUCTION: (CROHN'S ONLY) **Check:** ☐ 400 mg (200 mg x 2) at weeks 0, 4, and 8 **Check one:** ☐ Pen Refills: 2 ☐ Prefilled Syringe (PFS) Refills: 2

INTRAVENOUS INDUCTION: (CROHN'S OR ULCERATIVE COLITIS) **Check:** ☐ 200 mg IV at weeks 0, 4, and 8 Vials # (for 1 infusion) 1 Refills: 2

Ship to Induction or Infusion Site: (ONLY REQUIRED IF DIFFERENT FROM PRESCRIBER'S OFFICE. Shipments cannot be sent to PO boxes.)

☐ Nonprescriber's Office ☐ Hospital Outpatient ☐ Infusion Center ☐ Other

PHYSICIAN OR INFUSION PROVIDER NAME _____ OFFICE CONTACT NAME _____

PRACTICE/FACILITY NAME _____ NPI# _____ TAX ID# _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

PHONE _____ FAX _____

STEP 2: Complete maintenance information: Dosing and Device

DOSING: (CROHN'S OR ULCERATIVE COLITIS) CHECK ONE

☐ 200 mg SC at week 12 then q4 weeks Check one device: ☐ Pen Refills: _____ **OR** ☐ PFS Refills: _____

OR

☐ 100 mg SC at week 16 then q8 weeks Check one device: ☐ Pen Refills: _____ **OR** ☐ PFS Refills: _____ **OR** ☐ One-Press Patient-Controlled Injector Refills: _____

PRESCRIBER SIGNATURE(S) (NO STAMPS ALLOWED) REQUIRED TO VALIDATE PRESCRIPTION: I certify that therapy with TREMFYA® is medically necessary for this patient. I will be supervising the patient's treatment accordingly, and I have reviewed the current TREMFYA® Prescribing Information. By signing below, I authorize the Pharmacy, its affiliates, agents, and contractors to, as applicable, (i) dispense this prescription to patient with patient's consent if eligible for the TREMFYA withMe Trial Offer, TREMFYA withMe Access Program, and/or Johnson & Johnson Patient Assistance Program; and (ii) act on my behalf for the limited purposes of transmitting this prescription, by any means allowed under applicable law, to the appropriate pharmacy designated by the patient utilizing their benefit plan.

TREMFYA® Support Program Prescription

Signature required to enroll eligible patients in the TREMFYA withMe Trial Offer **(CROHN'S - SUBCUTANEOUS INDUCTION ONLY)**, TREMFYA withMe Access Program, or Johnson & Johnson Patient Assistance Program. If the patient qualifies for and enrolls in the TREMFYA withMe Trial Offer, TREMFYA withMe Access Program, or Johnson & Johnson Patient Assistance Program, this prescription will be used by the Pharmacy to dispense the patient's TREMFYA®.

By submitting the prescription, I understand, if a subcutaneous induction prescription is selected above, the patient, if eligible, will be offered to trial their first subcutaneous induction dose of TREMFYA® at no cost through the TREMFYA withMe Trial Offer. Additionally, by submitting the prescription, I understand the Pharmacy will check the patient's eligibility for and may, based on the results, and with the patient's consent, (i) send the Trial Offer subcutaneous induction dose, (ii) enroll the patient in the TREMFYA withMe Access Program, or (iii) enroll the patient in the Johnson & Johnson Patient Assistance Program. If the patient is eligible for the Trial Offer or one of the other programs, I certify that I agree to the applicable program requirements and will take the necessary actions described in the requirements for the patient. See program descriptions on page 2.

PRESCRIBER SIGNATURE (Dispense as written) _____ DATE _____

Commercial Pharmacy Prescription (optional)

Patient- or provider-preferred pharmacy _____

PRESCRIBER SIGNATURE (Dispense as written) _____ DATE _____

Please see the full Prescribing Information and Medication Guide for TREMFYA®.

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

Information about your patient's insurance coverage, cost support options, and treatment support is given by service providers for TREMFYA 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, TREMFYA withMe cannot promise the information will be complete.

The patient support and resources provided by TREMFYA withMe are not intended to give medical advice, replace a treatment plan from the patient's healthcare provider, offer services that would normally be performed by the provider's office, or serve as a reason to prescribe TREMFYA®.

We will help 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 start and stay on TREMFYA®. Patient support is available for eligible patients prescribed TREMFYA®:

TREMFYA withMe Trial Offer:

With the TREMFYA withMe Trial Offer, eligible patients are able to receive their first subcutaneous induction dose of TREMFYA® at no cost to see if it's right for them. Patients must be commercially insured, 18 years of age or older and have a valid, signed on-label prescription. At the conclusion of the trial, the patient and their healthcare provider decide whether to continue treatment. Terms expire at the end of each calendar year and may change. To learn more, visit **TREMFYAwithMeTrial.com**.

TREMFYA withMe Savings Program:

Eligible patients using commercial or private insurance can save on out-of-pocket costs for TREMFYA®. Eligible patients may pay $0 per dose. See program requirements at **TREMFYAwithMeSavings.com**. After submitting this form, patient can expect to receive a call from their Case Manager for enrollment if eligible.

TREMFYA withMe Access Program:

TREMFYA withMe offers eligible patients TREMFYA® at no cost for up to 3 years or until their commercial insurance covers the medicine. See program requirements at **TREMFYAwithMeAccess.com**. To have your patient enrolled in the TREMFYA withMe Access Program if they are eligible, a TREMFYA® prescription must be completed in section 5.

TREMFYA withMe Nurse Guide* Outreach:

TREMFYA withMe offers a dedicated Nurse Guide at no cost to patients **age 18 and older who have been prescribed TREMFYA®** for on-label use. After submitting this form, your patient can expect to receive a phone call from their TREMFYA withMe Nurse Guide within 1–2 business days. The Nurse Guide will describe the program to your patient and complete the enrollment process. A TREMFYA withMe Nurse Guide cannot reach out to your patient without an executed Patient Authorization Form, which can be found on pages 3 and 4 of this document.

*Nurse Guides do not provide medical advice.

Johnson & Johnson Patient Assistance Program

Patient assistance is available if your patient is uninsured, or has commercial, employer-sponsored, or government coverage that does not fully meet their needs. Your patient may be eligible to receive their medicine from J&J at no cost for up to one year if they meet the following requirements:

- Your patient is uninsured or has a commercial or employer-sponsored insurance plan or government coverage, such as Medicare, Medicaid, TRICARE, U.S. Department of Veterans Affairs health care, or U.S. Department of Defense health care
- Your patient lives in the United States or a U.S. territory
- Your patient is treated as an outpatient by a healthcare provider licensed in the U.S.
- Your patient has been prescribed an eligible medicine from J&J
- Your patient meets the income eligibility requirements
- **For Medicare Part D Patients Only:**
  - Your patient spends more than 4% of their gross annual household income on prescription drugs
  - Your patient demonstrates they are not eligible for the Low-Income Subsidy (LIS)
    - LIS requirement applicable to patients whose income is equal to or less than 150% of Federal Poverty Level (FPL)

To learn more about income requirements, terms & conditions, please visit **PatientAssistanceInfo.com/IMM** or call 877-227-3728.

To have your patient enrolled in the Johnson & Johnson Patient Assistance Program if they are eligible, a TREMFYA® prescription is required in section 5.

Please see the full Prescribing Information and Medication Guide for TREMFYA®.

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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: TREMFYA withMe, 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 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 ***InnovativeMedicine.JNJ.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: 800-600-7226

TREMFYA withMe
PO Box 15510, Pittsburgh, PA 15244

Or, eSign a digital Form:

In your healthcare provider's office

At **Account.JNJwithMe.com**

