Janssen CarePath

Remicade® INFLIXIMAB | Infliximab

Janssen CarePath Savings Program
Patient Assignment of Benefits

1. **Please note that this completed form is required in order for the provider to receive a payment on behalf of the patient for medication costs.**
   - **When submitting an Explanation of Benefits (EOB), a copy of the Health Insurance Claim Form—CMS 1500 (HICF) or Uniform Billing Form—CMS 1450 (UB-04) must be included.**
2. **Effective 8/20/18, only providers with a JanssenCarePathPortal.com account will be able to submit this form. Visit JanssenCarePathPortal.com to create an account and upload this form online or fax it to 877-234-3048.**
3. **The patient who has directed that payment should be made to the provider must authorize the assignment of benefits by signing this form. All fields must be completed.**

Patient Information and Authorization

Patient: Date of Birth (mm/dd/yyyy):

Patient Address:

City: State: ZIP:

My signature on this Patient Assignment of Benefits Form confirms that I authorize my Janssen CarePath Savings Program benefits be sent on my behalf to the provider I have designated on this form for payment of my out-of-pocket Janssen medication cost. I also understand that I may, at any time, call Janssen CarePath and elect for the rebate check(s) to be sent directly to me or for my rebate to be loaded onto a debit card (if available).

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: _____

Treatment Provider Information and Authorization

Site Name: Site NPI:

Provider First Name: Provider Last Name:

Address: City: State: ZIP:

Site Phone: Site Fax:

My signature on this Patient Assignment of Benefits Form acknowledges that the patient listed above has requested their benefit from the Janssen CarePath Savings Program be sent to our Treatment Site for payment of the patient's eligible out-of-pocket Janssen medication costs. I further understand that patient may elect in the future for a rebate check to be sent directly to the patient or for the rebate to be loaded onto a debit card (if available). At that point, the patient's Janssen CarePath Savings Program benefit will no longer be sent to our Treatment Site.

Treatment Site Representative Signature: _____ Date:

Print Name: Treatment Site:

Please read the full Prescribing Information, including Boxed Warnings, and Medication Guides for REMICADE® and Infliximab, and discuss any questions you have with your doctor.