Stelara withMe

Stelara (ustekinumab)

STELARA withMe Savings Program Patient Assignment of Benefits

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 STELARA withMe.

1. **AUTHORIZATION:** By signing this form, the patient authorizes STELARA withMe to issue payment directly to their provider for any reimbursement amounts attributable to the costs of STELARA® administered in their provider's office. This form's authorization is not limited to one provider, but grants patient authorization for all of the patient's treatment providers who submit a rebate request to the STELARA withMe Savings Program.
2. **BENEFITS:** This form is limited to repayment of the costs of medication that are administered in the provider's office. It does not cover the cost of the office visit or the patient's treatment's administration.
3. **INSTRUCTIONS:** The patient must read this form, complete all fields, sign, and return this form to their provider if the patient is in agreement with the assignment of the above benefits to all providers from whom the patient receives medical services related to STELARA®. Patients or providers should fax the completed form to STELARA withMe at 866-769-3903, or mail to STELARA withMe, 2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560.
4. **CANCELLATION:** The patient can, at any time, call STELARA withMe and elect for the rebate check(s) (payment) to be sent directly to them.

Patient Information:

Patient Name: ______________________ Date of Birth (mm/dd/yyyy): ______________

STELARA withMe Savings Program Member #: ______________________
(from the front of your Savings Program card)

Patient Address: ______________________

City: ______________ State: ______ ZIP Code: ______________

Patient Authorization:

My signature on this Patient Assignment of Benefits Form confirms that I authorize that each of my STELARA withMe Savings Program out-of-pocket payment(s) for my out-of-pocket medication costs be sent on my behalf to all provider(s) for payment of my out-of-pocket STELARA® medication cost(s). I also understand that I may, at any time, call STELARA withMe and elect for the rebate check(s) to be sent directly to me.

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:

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Please read the full Prescribing Information and Medication Guide for STELARA®, available at JanssenCarePath.com and discuss any questions you may have with your doctor.

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