Janssen CarePath

Initiating benefits investigation is easy

For prescribers

- ☐ Complete the required Prescriber Information and Clinical Information sections on pages 1-3
- ☐ Complete the required Treatment Location Information section on page 2 (DARZALEX®, DARZALEX *FASPRO*®, PROCRIT®, RYBREVANT™, and YONDELIS® only)
- ☐ Complete the optional Prescription Information and the Preferred Pharmacy Information sections on page 3 (ERLEADA® and ZYTIGA® only)
- ☐ If prior authorization assistance is NOT needed, check the appropriate box in the Prior Authorization section on page 1 to opt out

For your patients/caregivers

- ☐ Complete or have your patient complete the Patient Information and Insurance Information sections on page 4
- ☐ As requested by your patient, complete or have your patient complete the Janssen CarePath Savings Program section on page 5 to determine eligibility
- ☐ If you do not have a signed Business Associate Agreement (BAA) on file with Janssen CarePath, have your patient read, sign, and date the Patient Authorization on pages 6-7
  - Give your patient a copy of the signed Patient Authorization form and keep the original for your records

Fax the completed and signed Benefits Investigation Form to Janssen CarePath at 855-998-4422

Here's what happens next

For prescribers

Janssen CarePath will:

- Medical Benefit: Confirm receipt of requests within 2 hours and verify benefits within 1 to 2 business days
- Pharmacy Benefit: Verify benefits within 4-6 business hours
- Provide you with a verification of benefits and call your patient to review the benefits

For your patients/caregivers

Janssen CarePath will:

- Call your patient to review the benefits and provide you with a verification of benefits
- Inform your patient about cost support options and offer your patient care coordination support services with the infusion provider or specialty pharmacy
- Enroll your eligible patient with commercial or private health insurance in the Janssen CarePath Savings Program, if requested by your patient

DARZALEX (daratumumab) injection for intravenous infusion 100 mg/5 mL, 400 mg/20 mL | DARZALEX Faspro (daratumumab and hyaluronidase-fihj) Injection for subcutaneous use | 1,800mg/30,000units | PROCRIT EPOETIN ALFA | RYBREVANT (amivantamab-vmjw) | Yondelis (trabectedin) | Erleada (apalutamide) 60 mg tablets | Zytiga abiraterone acetate

Medical Benefit | Pharmacy Benefit

Need help? Call **877-CarePath** (877-227-3728)
Monday–Friday, 8:00 AM–8:00 PM ET
Multilingual phone support available

Please see full Prescribing Information for DARZALEX®, DARZALEX *FASPRO*®, RYBREVANT™, YONDELIS®, ERLEADA®, and ZYTIGA®.
Please see full Prescribing Information, including Boxed Warnings and Medication Guide for PROCRIT®. Provide the Medication Guide to your patients and encourage discussion.

YONDELIS® (trabectedin) is under license from Pharma Mar, S.A.

Janssen CarePath UPDATE 5.21

Benefits Investigation Form

1. Prescriber Information—to be completed by Physician (Required)

Prescriber Name (First, Last) _____ Specialty _____

Practice Name _____ Office Contact _____

Address _____

City _____ State _____ ZIP _____

Email _____ Phone _____ Fax _____

Medicaid/Medicare Provider # _____ Tax ID # _____

State License # _____ UPIN/NPI # _____

2. Prior Authorization—to be completed by Physician (Optional)

Automatically provided with benefits investigation. You may opt out by checking the box below.

Prior Authorization Form Assistance and Status Monitoring: Janssen CarePath assists your office in providing the requirements of the patient's health plan related to prior authorization for treatment with the medication specified on this form. Assistance includes obtaining the health-plan-specific prior authorization form and providing it based upon the patient-specific information provided on this form. The partially completed prior authorization form, if received from the health plan, will be provided to your office for possible completion and submission in the office's sole discretion. Janssen CarePath also actively monitors the status of prior authorization submission to the patient's plan and provides status updates to your office with respect to this patient's prior authorization for treatment with the medication specified on this form.

☐ I do **NOT** wish to receive Prior Authorization Form Assistance or Status Monitoring.

By providing your information and information about your patient on the Benefits Investigation Form, you are requesting the services described on this form. The information you provide will only be used by Johnson & Johnson Health Care Systems Inc., our affiliates, and our service providers involved in delivering these services. You may withdraw your request for these services by calling 877-CarePath (877-227-3728). Our Privacy Policy governs the use of the information you provide. By providing the information and submitting this form, you indicate you read, understand, and agree to these terms.

Patient insurance benefits investigation and other Janssen CarePath program offerings are provided by third-party service providers for Janssen CarePath, under contract with Johnson & Johnson Health Care Systems Inc. on behalf of Janssen Pharmaceuticals, Inc., Janssen Biotech, Inc., and Janssen Products, LP (Janssen). Janssen CarePath is not available to patients participating in the Patient Assistance Program offered by Johnson & Johnson Patient Assistance Foundation. The availability of information and assistance may vary based on the Janssen medication, geography and other program differences. Janssen CarePath assists healthcare providers (HCPs) in the determination of whether treatment could be covered by the applicable third-party payer based on coverage guidelines provided by the payer, and patient information provided by the HCP under appropriate authorization following the provider's exclusive determination of medical necessity. This information and assistance are made available as a convenience to patients, and there is no requirement that patients or HCPs use any Janssen product in exchange for this information or assistance. Janssen assumes no responsibility for and does not guarantee the quality, scope, or availability of the information and assistance provided. The third-party service providers, not Janssen, are responsible for the information and assistance provided under this program. Each HCP and patient is responsible for verifying or confirming any information provided. All claims and other submissions to payers should be in compliance with all applicable requirements.

Janssen CarePath

Benefits Investigation Form

3. Clinical Information for Benefits Investigation: IV/SubQ Only—to be completed by Physician (Required)

Medication

☐ DARZALEX® (daratumumab) ☐ DARZALEX *FASPRO*® (daratumumab and hyaluronidase-fihj) ☐ PROCRIT® (epoetin alfa)
☐ RYBREVANT™ (amivantamab-vmjw) ☐ YONDELIS® (trabectedin)

Treatment Information

Primary Diagnosis Code _____ Primary Diagnosis Indication _____

Approximate Date of Patient's Diagnosis (mm/dd/yyyy) _____

Secondary Diagnosis (Optional) _____

Dosage Form and Strength _____ No. of Vials _____

Administration _____

Patient Weight _____ lbs _____ kg

Has the patient started therapy with the medication specified above? ☐ Yes ☐ No

If yes, what date did the patient start therapy? (mm/dd/yyyy) _____

Additional information regarding treatment (if applicable to benefits verification) _____

_____

DARZALEX® and DARZALEX *FASPRO*® only:

☐ Monotherapy
☐ Combination Therapy

If Combination, list medications:

_____

_____

_____

Prior Medications/Treatments:

_____

_____

_____

PROCRIT® only:

Initial HCT _____ %

Initial Hb _____ g/dL

For cancer patients, is the patient on chemotherapy? ☐ Yes ☐ No

Is the patient a nephrology patient? ☐ Yes ☐ No

If nephrology patient, what is the patient's:

Serum creatinine _____ mg/dL

Creatinine clearance _____ mL/min

Is the patient taking PROCRIT® preoperatively? ☐ Yes ☐ No

If yes, surgery type _____

RYBREVANT™ only:

Is the patient Exon 20 positive? ☐ Yes ☐ No

Is the patient currently on or have they previously taken a platinum-based chemotherapy? ☐ Yes ☐ No

If yes, list which platinum-based chemotherapy:

_____

_____

_____

YONDELIS® only:

Patient Height _____ ft _____ in

Patient BSA _____

Has the patient taken a prior chemotherapy? ☐ Yes ☐ No

If yes, what prior chemotherapy has the patient taken?

☐ Anthracycline
☐ Ifosfamide
☐ Other _____

☐ Please investigate benefits for YONDELIS® infused through an ambulatory pump through a central venous catheter

4. Treatment Location Information: IV/SubQ Only—to be completed by Physician (Required)

Treatment Location Type

☐ Prescribing MD's Office ☐ Non-prescribing MD's Office ☐ Home Infusion/Infusion Provider Company
☐ Hospital Outpatient ☐ Hospital Inpatient ☐ Other _____

Provider Information

If prescribing MD's office, the fields below do not need to be completed if information is the same as the Prescriber Information section.

Provider Name (First, Last) _____ Physician Specialty _____

Practice Name _____

Address _____

City _____ State _____ ZIP _____

Site Phone _____ Site Fax _____

Insurance Provider # _____ Tax ID # _____

Please see full Prescribing Information for DARZALEX®, DARZALEX *FASPRO*®, RYBREVANT™, and YONDELIS®.

Please see full Prescribing Information, including Boxed Warnings and Medication Guide for PROCRIT®. Provide the Medication Guide to your patients and encourage discussion.

5. Clinical Information for Benefits Investigation: Orals Only—to be completed by Physician (Required)

Medication

ERLEADA® (apalutamide) ☐ 60 mg Tablet Dosing: 240 mg PO once daily with or without food Quantity _____

ZYTIGA® (abiraterone acetate) ☐ 250 mg Tablet Dosing: _____ mg PO _____ daily on an empty stomach Quantity _____

☐ 500 mg Film-Coated Tablet Dosing: _____ mg PO _____ daily on an empty stomach Quantity _____

Treatment Information

Primary Diagnosis Code: C61 Primary Diagnosis Indication: Malignant neoplasm of prostate

Approximate Date of Patient's Diagnosis (mm/dd/yyyy) _____

6. Prescription Information: to be completed by Physician (Optional)

If requesting benefits investigation only, do not complete this section. The prescription is only valid if received by fax. If not faxed, prescription must be submitted on state-specific blank, if applicable for your state.

Patient Name (First, MI, Last) _____ Date of Birth _____

Rx ERLEADA® ☐ 60 mg Tablet

Directions: Take 240 mg PO once daily with or without food Quantity _____ Refills # _____

Rx ZYTIGA® ☐ 250 mg Tablet ☐ 500 mg Film-Coated Tablet

Directions: Take _____ mg PO _____ daily on an empty stomach Quantity _____ Refills # _____

Initial Dosing: For patients with baseline moderate hepatic impairment (Child-Pugh Class B), reduce the ZYTIGA® starting dose to 250 mg once daily (see Dose Medication Guidelines for more information). Do not use ZYTIGA® in women who are or may become pregnant and patients with baseline severe hepatic impairment (Child-Pugh Class C). Refer to the ZYTIGA® full PRESCRIBING INFORMATION, including the following sections: INDICATIONS AND USAGE, CONTRAINDICATIONS, DOSAGE AND ADMINISTRATION, WARNINGS AND PRECAUTIONS, ADVERSE REACTIONS, DRUG INTERACTIONS, and USE IN SPECIFIC POPULATIONS prior to initiating treatment.

Rx Prednisone ☐ 5 mg Tablet

Directions: Take _____ Quantity _____ Refills # _____

Prednisone is required to be taken with ZYTIGA®; however, it is optional to include on this Benefits Investigation Form. You may provide a prescription direct to the patient to be filled at a pharmacy that can fill the script. NOTE: Janssen CarePath will not investigate benefits for prednisone. Please refer to full Prescribing Information for complete information prior to initiating treatment.

Prescriber Name (if different from page 1) _____

Address _____

City _____ State _____ ZIP _____

Phone _____ Fax _____

PRESCRIBER SIGNATURE (NO STAMPS) REQUIRED. I certify that therapy with the Janssen medication indicated above is medically necessary for this patient. I will be supervising the patient's treatment accordingly, and I have reviewed the current Prescribing Information for the Janssen medication indicated above. I authorize Janssen CarePath to act on my behalf for the limited purposes of transmitting this prescription to the appropriate pharmacy designated by me, the patient, or the patient's plan.

Prescriber Signature >> (Dispense as written) _____ Date _____

Prescriber Signature >> (Substitutions allowed) _____ Date _____

Supervising Physician Signature >> (If applicable) _____ Date _____

Supervising Physician Name _____

7. Preferred Pharmacy: Orals Only—to be completed by Physician (Optional)

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 below, provided it is approved by this patient's plan. **2.** If the SP designated is not a plan-approved SP, then to an 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.

Preferred Specialty Pharmacy _____ ☐ Self-Dispensing Pharmacy

Please see full Prescribing Information for ERLEADA® and ZYTIGA®.

Janssen CarePath

Benefits Investigation Form

8. Patient Information (Required)

Name (First, MI, Last) _____ Language ☐ English ☐ Spanish

☐ Male ☐ Female Date of Birth (mm/dd/yyyy) _____

Address _____

City _____ State _____ ZIP _____

Primary Email _____ Secondary Email (Optional) _____

Primary Phone _____ Secondary Phone (Optional) _____ Best Time to Contact _____

Caregiver/Contact _____
(A caregiver/contact is someone who can be contacted in place of the patient)

Home/Cell Phone _____ Work Phone _____ Best Time to Contact _____

☐ I authorize Janssen CarePath to leave a message, including the name of the Janssen medication indicated on this form, if I am unavailable when they call.

☐ If I cannot be reached, I authorize Janssen CarePath to contact my caregiver.

☐ I prefer and authorize Janssen CarePath to contact my caregiver in place of me.

9. Insurance Information (Required)

Please provide insurance information for all health insurance coverage you may have.

☐ **Please see attached front and back copy of insurance card.**

Primary Medical Insurance: required for DARZALEX® (daratumumab), DARZALEX *FASPRO*® (daratumumab and hyaluronidase-fihj), RYBREVANT™ (amivantamab-vmjw), YONDELIS® (trabectedin), PROCRIT® (epoetin alfa)

Primary Insurance Carrier _____ Phone _____

Cardholder Name (First, MI, Last) _____ Relationship to Cardholder _____

Policy # _____ Group # _____

Secondary Medical Insurance (Optional)

Secondary Insurance Carrier _____ Phone _____

Cardholder Name (First, MI, Last) _____ Relationship to Cardholder _____

Policy # _____ Group # _____

Prescription Drug Insurance: required for ERLEADA® (apalutamide), ZYTIGA® (abiraterone acetate)

Prescription Drug Insurer _____ Card BIN # _____ Phone _____

Cardholder Name (First, MI, Last) _____ Relationship to Cardholder _____

Policy # _____ Group # _____

☐ **Please investigate out-of-network benefits.**

Please see full Prescribing Information for DARZALEX®, DARZALEX *FASPRO*®, RYBREVANT™, YONDELIS®, ERLEADA®, and ZYTIGA®.
Please see full Prescribing Information, including Boxed Warnings and Medication Guide for PROCRIT®. Provide the Medication Guide to your patients and encourage discussion.

Janssen CarePath

Benefits Investigation Form

10. Janssen CarePath Savings Program (Optional)

Eligible patients using commercial insurance can save on out-of-pocket Janssen medication costs. See program requirements at JanssenCarePath.com.

☐ I would like Janssen CarePath to check the patient's eligibility for and enroll the patient into the Janssen CarePath Savings Program if the results of this benefits investigation determine that the patient has commercial or private health insurance.

Rebate Type for DARZALEX® (daratumumab), DARZALEX *FASPRO*® (daratumumab and hyaluronidase-fihj), RYBREVANT™ (amivantamab-vmjw), or YONDELIS® (trabectedin)

Please select how the patient would like to receive their rebate if the consent above is checked and benefits investigation is for DARZALEX®, DARZALEX *FASPRO*®, RYBREVANT™, or YONDELIS®

☐ **Load Funds onto Card** ☐ **Mail Check to Patient** ☐ **Mail Check to Provider*** (please select one option below)

☐ Prescriber Office ☐ Treatment Location

*By selecting this option, I understand that I am requesting that Janssen CarePath Savings Program rebate check(s) will be sent on behalf of the patient to the designated provider for payment of the patient's out-of-pocket Janssen medication costs. I also understand that I may, at any time, call Janssen CarePath and elect for the rebate check(s) to be sent directly to the patient.

Eligibility Questions

1. Will the patient use commercial or private health insurance for their Janssen medication? (Examples are commercial insurance from a current/former employer, government employee health insurance, or insurance the patient buys privately or through the Health Insurance Marketplace)

☐ **Yes**, the patient has commercial or private health insurance that they will use for their Janssen medication

☐ **No**, the patient does not have commercial or private health insurance that they will use for their Janssen medication

2. Do you confirm the patient will NOT ask any government-funded healthcare program to cover any Janssen medication costs? (Examples are Medicare Parts A, B, C (also known as Medicare Advantage Plan), D, and Medicare Supplement, Medicaid, TRICARE, Department of Defense, or Veterans Administration)

☐ **Yes**, I confirm the patient will NOT seek payment from any government-funded healthcare program for their Janssen medication

☐ **No**, the patient may seek payment from a government-funded healthcare program for their Janssen medication

3. Do you confirm the patient will NOT submit any costs paid by this program as a claim for payment to any health plan, patient assistance foundation, flexible spending account, or healthcare savings account?

☐ **Yes**, I confirm that the patient will NOT submit out-of-pocket costs paid by this program as a claim

☐ **No**, the patient may submit out-of-pocket costs paid by this program as a claim

Please see full Prescribing Information for DARZALEX®, DARZALEX *FASPRO*®, RYBREVANT™, and YONDELIS®.

Janssen CarePath

Janssen Patient Support Program Patient Authorization Form

- **Patients should read the Patient Authorization, check the desired permission boxes, and return 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 855-998-4422 or mailed to Janssen CarePath, 2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560**
  - **You may be able to eSign a digital form in your healthcare provider's office**

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.

My "Protected Health Information" includes but is not limited to the following 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 include foundations and co-pay assistance providers
- Service providers supporting or analyzing data from Janssen patient support programs

Specifically, 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, and contact me about Janssen patient support programs
- 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 confirm to my Healthcare Provider that support has been provided by the 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

I understand that my Protected Health Information will not be used or shared by Janssen for any other use without my permission. Janssen may share information about me where legally allowed or if any information that specifically identifies me is removed. I understand that Janssen will make every effort to keep my information private. Further, I understand that if my information is accidentally shared, federal privacy laws do not require that the person/party receiving it not share the information further and that such information provided to a third party may no longer be protected by federal privacy laws.

Janssen CarePath

Janssen Patient Support Program Patient Authorization Form

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. 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.

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, 2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560.

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 sign here: _____ **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:

_____

Janssen