

Dermatologist Benefits Investigation and Prescription Form

Complete and fax this form to 866-769-3903 or mail to 2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560.
For assistance, call 877-CarePath (877-227-3728), Monday-Friday, 8:00 AM-8:00 PM ET

Janssen CarePath cannot accept any information without an executed **Business Associate Agreement** or **Patient Authorization Form**, which can be found at JanssenCarePath.com or as the last page of this document.

1. PATIENT INFORMATION (REQUIRED)

NAME (First, MI, Last) _____ SEX M F
 ADDRESS _____
 CITY _____ STATE _____ ZIP CODE _____ DOB (MM/DD/YYYY) _____
 PRIMARY PHONE (Best number to call 8:00 AM to 8:00 PM) _____

2. INSURANCE INFORMATION (REQUIRED. Include alpha prefix and suffix with policy and group # when applicable or provide a copy of insurance cards)

MEDICAL INSURANCE _____
 CARDHOLDER _____
 DATE OF BIRTH _____ POLICY# _____ GROUP# _____
PHARMACY INSURANCE _____ PCN# _____
 CARDHOLDER _____ DATE OF BIRTH _____
 Rx ID _____ Rx BIN# _____ GROUP# _____
SECONDARY INSURANCE _____ CARDHOLDER _____
 DATE OF BIRTH _____ POLICY# _____ GROUP# _____

3. CLINICAL INFORMATION (REQUIRED. The information requested is for benefits investigation only. Visit JanssenCarePath.com for ICD-10 codes or consult the ICD-10 code book for additional information)

PRIMARY DIAGNOSIS: PSORIASIS L40.0 (Psoriasis vulgaris) Other ICD-10 Code _____
 PSORIATIC ARTHROPATHY L40.50 (Arthropathic psoriasis, unspecified) Other ICD-10 Code _____
SECONDARY DIAGNOSIS: ICD-10 CODE _____
 TB TEST DATE _____ DATE OF DIAGNOSIS OR YEARS WITH DISEASE _____
 PATIENT WEIGHT _____ lb. _____ kg. % BSA AFFECTED _____
PRIOR THERAPIES (REQUIRED TO COMPLETE PRIOR AUTHORIZATION)
 Arava® Corticosteroids Cosentyx® Cyclosporine Enbrel® Humira® Methotrexate Otezla® Phototherapy
 Skyrizi® Soriatane® Taltz® Tremfya® Xeljanz® None Other _____

4. BENEFITS INVESTIGATION

I would like to request investigation of benefits only for STELARA® at this time 45 mg single-dose prefilled syringe 90 mg single-dose prefilled syringe
 I would like to request investigation of benefits only for STELARA® 45 mg single-dose vial 1 vial 2 vials
SITE OF CARE Prescribing MD's Office Non-prescribing MD's Office/Infusion Center Hospital Outpatient Other _____
 PHYSICIAN OR INFUSION PROVIDER NAME _____
 PRACTICE/FACILITY NAME _____
 ADDRESS _____
 CITY _____ STATE _____ ZIP CODE _____
 PHONE _____ FAX _____ CONTACT NAME _____
 INSURANCE PROVIDER# _____ TAX ID# _____

Please see full [Prescribing Information](#) and [Medication Guide](#) for STELARA®. Provide the Medication Guide to your patients and encourage discussion.

5. PRESCRIBER INFORMATION (REQUIRED)

PRESCRIBER NAME (First, Last) _____
 PRACTICE NAME _____ OFFICE CONTACT _____
 ADDRESS _____
 CITY _____ STATE _____ ZIP CODE _____
 PHONE _____ FAX _____ TAX ID# _____
 MEDICAID/MEDICARE PROVIDER# _____ NPI# _____

6. SO SIMPLE TRIAL PROGRAM PRESCRIPTION: OFFER ONLY FOR 45 mg VIAL

Trial Dose for pediatric patients (ages 6-17) weighing less than 60 kg: One 45 mg vial; 0.75 mg/kg SC at Week 0

SHIP STARTER DOSE TO: Prescriber office Patient

PRESCRIBER SIGNATURE REQUIRED TO VALIDATE PRESCRIPTION: I certify that therapy with STELARA® is medically necessary for this patient. I will be supervising the patient's treatment accordingly, and I have reviewed the current STELARA® full Prescribing Information. I authorize Janssen CarePath to act on my behalf for the limited purposes of transmitting this prescription to Wegmans Pharmacy. I also indicate that I would like to enroll the patient in the So Simple Trial Program. I understand that the patient will be contacted by Wegmans Pharmacy, on behalf of Janssen CarePath, to initiate therapy and schedule shipping of his/her medication.

PRESCRIBER SIGNATURE (NO STAMPS ALLOWED) _____ DATE _____

7. PRESCRIPTION INFORMATION (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)

Rx DIRECTIONS (select all that apply)

45 mg VIAL STARTER DOSE for plaque psoriasis (ages 6-17) weighing less than 60 kg

45 mg VIAL MAINTENANCE THERAPY for plaque psoriasis (ages 6-17) weighing less than 60 kg

If So Simple Trial Program selected above:

45 mg single-dose vial; 0.75 mg/kg SC at Week 4
 45 mg single-dose vial; 0.75 mg/kg SC at Week 0 and Week 4

45 mg single-dose vial; 0.75 mg/kg SC every 12 weeks Refills # _____

PREFILLED SYRINGE STARTER DOSE

Single-dose prefilled syringe; 45 mg SC at Week 0 Week 4
 Single-dose prefilled syringe; 90 mg SC at Week 0 Week 4

PREFILLED SYRINGE MAINTENANCE THERAPY

Single-dose prefilled syringe; 45 mg SC every 12 weeks Refills # _____
 Single-dose prefilled syringe; 90 mg SC every 12 weeks Refills # _____

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

8. JANSSEN LINK PROGRAM

When commercial insurance coverage is delayed >5 business days or denied, Janssen Link offers eligible patients subcutaneous STELARA® at no cost until their commercial insurance covers the medication. See program requirements on the next page.
 By enrolling patients in Janssen Link, I certify that I agree to the program requirements and will take any necessary action described in the requirements for my patient.

PRESCRIBER SIGNATURE (NO STAMPS ALLOWED) _____ DATE _____

9. PRIOR AUTHORIZATION

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 STELARA®. 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 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 STELARA®.

I do NOT wish to receive Prior Authorization Form Assistance or Status Monitoring. This opt-out does not apply if you are requesting the patient be enrolled in Janssen Link.
 Prior Authorization is already on file with the patient's plan for treatment with subcutaneous STELARA®.

The information you provide will be used by Janssen Biotech, Inc., our affiliates, and our service providers for your enrollment and participation in Janssen CarePath. You may withdraw by calling 877-CarePath (877-227-3728). Our Privacy Policy, available at [JanssenCarePath.com/Privacy-Policy](https://www.janssencarepath.com/Privacy-Policy), further governs the use of the information you provide. By providing the information and submitting this form, you indicate that 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 Link offers eligible patients subcutaneous STELARA® (ustekinumab) **at no cost** until their commercial insurance covers the medication. See program requirements below.

Janssen Link Program Requirements

To be eligible, patient must have:

1. a subcutaneous STELARA® 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 program enrollment form*
5. 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.

Program 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.

Participating prescribers authorize Janssen CarePath to:

1. conduct a benefits investigation and confirm prior authorization requirements
2. provide prior authorization form assistance and status monitoring, including the exceptions and appeals processes
3. refer eligible patients to Wegmans Specialty Pharmacy for further program support and shipment of medication
4. support the transition of patients to commercial product if the medication is covered
5. check insurance coverage status during the program.

*Janssen CarePath cannot accept any information without an executed Business Associate Agreement and/or Patient Authorization on file. The Patient Authorization can be found on this form, or patient can create an account on [MyJanssenCarePath.com](https://www.janssencarepath.com) and electronically sign a patient authorization there.

Janssen CarePath Patient Authorization

- **Patients should read the Patient Authorization and sign electronically or download, print, and sign.**
 - **Completed form may be uploaded to Patient Account or Provider Portal, faxed to Janssen CarePath at 844-286-5444, or mailed to address below.**
- **Patients can access a copy of completed form in their Janssen CarePath Account – My Profile.**

My signature on this Patient Authorization Form confirms that I authorize each of my physicians, pharmacists, including any specialty pharmacy that receives my prescription for a Janssen medication and other healthcare providers (together, “Healthcare Providers”) and each of my health insurers (together, “Insurers”) to disclose my protected health information, including but not limited to information related to my medical condition and treatment, my health insurance coverage, my name, address, telephone number, insurance plan, and/or group numbers (together, “Protected Health Information”) to Johnson & Johnson Health Care Systems Inc., its affiliated companies, agents, and representatives (together, “Janssen”), including providers of alternate sources of funding for prescription drug costs, and other approved service providers authorized to manage, administer, and/or support Janssen CarePath programs, Janssen CarePath Account for Patients, and Provider Portal for their Healthcare Providers for the purposes described below.

Specifically, I authorize Janssen to receive, use, and disclose my Protected Health Information in order to (i) enroll me in, determine my eligibility for, and contact me about Janssen medication support programs; (ii) provide me with educational materials, information, and services related to my Janssen medication; (iii) verify, investigate, assist with, and coordinate my coverage for my Janssen medication with my Insurers; (iv) coordinate prescription fulfillment; (v) assist with analyses related to the quality, efficacy, and safety of my Janssen medication, and patient access to and adherence to my Janssen medication; (vi) share and provide access to information generated by Janssen CarePath that may be useful for my care, and; (vii) improve, develop, and evaluate Janssen CarePath, its offerings, and materials. I also understand that pharmacies that ship my medication may be paid to share this information with Janssen CarePath to help provide the offerings requested for me. Furthermore, I understand that my Protected Health Information will not be used or disclosed by Janssen for any other purpose without my prior authorization unless permitted by law or unless 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 disclose the information further and that such information provided to a third party may no longer be protected by federal privacy laws.

I understand that I am not required to sign this Patient Authorization Form. My choice about whether to sign will not change the way my Healthcare Providers or Insurers treat me. If I refuse to sign the Patient Authorization Form, or revoke my authorization later, I understand that this means I will not be able to participate or receive assistance from Janssen CarePath.

This authorization will last until I am no longer participating in Janssen CarePath or accessing my Janssen CarePath Account. I understand that I may cancel or revoke this Authorization at any time by mailing a letter requesting such cancellation to Janssen CarePath, 2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560 or by informing my Healthcare Providers and Insurers in writing that I do not want them to share any information with Janssen. I further understand that cancellation or revocation will not affect Janssen’s ability to use and disclose Protected Health Information that it has received prior to its receipt of my cancellation and revocation of participation in the program. My authorization will also end if Janssen CarePath support programs or the Janssen CarePath Account is discontinued. Furthermore, I understand that I have the right to see or copy the Protected Health Information my Healthcare Providers or Insurers have given to Janssen.

Patient name: _____ Date of birth (mm/dd/yyyy): _____

Patient address: _____

City: _____ State: _____ ZIP Code: _____

Patient sign here: _____ Date: _____

If 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 CarePath
2250 Perimeter Park Drive, Suite 300
Morrisville, NC 27560
Fax 844-286-5444