UPDATE 4.21

Janssen CarePath

Rheumatologist 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

Stelara® (ustekinumab)

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) _____

DOB (MM/DD/YYYY) _____ ZIP CODE _____

CELL PHONE _____ ALTERNATE PHONE _____

PREFERRED NUMBER TO CALL ☐ CELL ☐ ALTERNATE BEST TIME TO CONTACT ☐ MORNING ☐ AFTERNOON ☐ EVENING

2. INSURANCE INFORMATION (REQUIRED. Please fill out this section in its entirety.)

PRIMARY MEDICAL INSURANCE _____ PHARMACY BENEFIT OR SECONDARY INSURANCE _____

CARDHOLDER _____ CARDHOLDER _____

PHONE _____ PHONE _____

GROUP # _____ POLICY # _____ GROUP # _____ POLICY # _____

3. CLINICAL INFORMATION (REQUIRED. The information requested is for benefits investigation purposes 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 _____ PATIENT WEIGHT _____ lb. or _____ kg.

PRIOR MEDICATIONS (REQUIRED TO COMPLETE PRIOR AUTHORIZATION)

☐ Corticosteroids ☐ Cyclosporine ☐ Enbrel® ☐ Humira® ☐ Methotrexate ☐ Otezla® ☐ Phototherapy ☐ Skyrizi® ☐ Soriatane® ☐ None of the above ☐ Other _____

4. PRESCRIBER INFORMATION (REQUIRED)

PRESCRIBER NAME (First, Last) _____ OFFICE CONTACT NAME _____

SITE NAME _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

PHONE _____ FAX _____ TAX ID # _____ NPI # _____

5. SO SIMPLE TRIAL PROGRAM PRESCRIPTION

STARTER DOSE:
☐ 1 single-use prefilled syringe; **45 mg** SC at Week 0
☐ 1 single-use prefilled syringe; **90 mg** SC at Week 0

SHIP STARTER DOSE TO:
☐ Prescriber office
☐ Patient

PRESCRIBER SIGNATURE (NO STAMPS ALLOWED) 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 (Dispense as written) _____ DATE _____

6. 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 **STELARA® DIRECTIONS**

STARTER DOSES REQUESTED SHIP DATE _____
☐ 2 single-use prefilled syringes; **45 mg** SC at Week 0 and Week 4
☐ 2 single-use prefilled syringes; **90 mg** SC at Week 0 and Week 4

MAINTENANCE THERAPY REQUESTED SHIP DATE _____
☐ 1 single-use prefilled syringe; **45 mg** SC every 12 weeks Refills # _____
☐ 1 single-use prefilled syringe; **90 mg** SC every 12 weeks Refills # _____

PRESCRIBER SIGNATURE (NO STAMPS ALLOWED) 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 the appropriate pharmacy designated by me, the patient, or the patient's plan.

PRESCRIBER SIGNATURE (Dispense as written) _____ DATE _____

7. 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 _____

8. BENEFITS INVESTIGATION

☐ **I would like to request investigation of benefits only for STELARA® at this time** ☐ 45 mg single-use prefilled syringe ☐ 90 mg single-use prefilled syringe

☐ **I would like to request investigation of medical benefits for STELARA® 45 mg single-dose vial** ☐ 1 vial ☐ 2 vials

SITE OF CARE (Complete if different than prescribing MD's office): ☐ Non-prescribing MD's office ☐ Hospital outpatient ☐ Home infusion/infusion provider company ☐ Other

PHYSICIAN OR INFUSION PROVIDER NAME _____

PRACTICE/FACILITY NAME _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

PHONE _____ FAX _____ CONTACT NAME _____

INSURANCE PROVIDER # _____ TAX ID # _____

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®.**

Please see full Prescribing Information and Medication Guide for STELARA®. Provide the Medication Guide to your patients and encourage discussion.

By providing your information and information about your patient on this form, you are requesting the services described on this form. The information you provide will only be used by Janssen Biotech, 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, available at **JanssenCarePath.com/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 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** and electronically sign a patient authorization there.

Janssen
PHARMACEUTICAL COMPANIES OF
Johnson & Johnson

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