



Medical Benefit Rebate Form

Complete this Medical Benefit Rebate Form only if you are submitting an **Explanation of Benefits (EOB)** for a rebate check to be sent directly to the patient.

Receive a Rebate in 4 Easy Steps

- 1 The patient must be enrolled in the Janssen CarePath Savings Program before receiving a Janssen medication. Patient can enroll by calling 877-CarePath (877-227-3728) or online at MyJanssenCarePath.com.
- 2 Patient must complete the information below and sign the form.
- 3 Include a copy of the following documents:
 - Explanation of Benefits (EOB) from patient’s primary insurance provider (as well as any secondary insurance provider, if applicable);
 - Receipt from the treatment provider indicating proof of payment of patient’s out-of-pocket Janssen medication costs. Valid receipt will include patient name, medication (name, J code, or NDC#), date, and amount of out-of-pocket responsibility paid for patient’s medication. If patient does not have proof of payment for the medication, patient must obtain their site representative’s signature below.
- 4 Submit this form online (if site representative signature is required), by fax, or by mail along with EOB and proof of payment (see below for details). Patient should only submit this form online if site representative signature is required for proof of payment. Eligible patients will receive a rebate check in about three weeks.

If you are submitting a **pharmacy receipt** and want to receive a rebate check, only complete the Pharmacy Benefit Rebate Form on the next page.

Complete the information below. *Required

The information you provide will only be used by Janssen Biotech, Inc., our affiliates, and our service providers, to provide benefits to you related to your participation in the Janssen CarePath Savings Program for STELARA®. If you want to stop receiving this information or service, you may withdraw from the program by calling 877-CarePath (877-227-3728). Our [Privacy Policy](#) governs the use of the information you provide.

*Name	E-mail	*Phone		
				Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
*11-digit ID# found on the front of the savings card		*Date of Birth (mm/dd/yyyy)		
*Address	*City	*State	*ZIP	

You may not seek payment for the value received from this program from any health plan, patient assistance foundation, flexible spending account, or healthcare savings account. This program is only for people age 6 or older using commercial or private health insurance for their Janssen medication. This includes plans from the Health Insurance Marketplace. This program is not for people who use any state or federal government-funded healthcare program. Examples of these programs are Medicare, Medicaid, TRICARE, Department of Defense, and Veterans Administration.

You must meet the program requirements every time you use the program. Program terms will expire at the end of each calendar year. The program may change or end without notice, including in specific states. **To use this program, you must follow any health plan requirements, including telling your health plan how much co-payment support you get from this program. By getting a Savings Program benefit, you confirm that you have read, understood, and agree to the program requirements on this page, and you are giving permission for information related to your Savings Program transactions to be shared with your healthcare provider(s). These transactions include rebates and any funds placed on the card or balance remaining on the card.** Offer good only in the United States and its territories. Void where prohibited, taxed, or limited by law. REBATE FORM CANNOT BE BOUGHT, TRANSFERRED, OR SOLD. REBATE FORM CANNOT BE COMBINED WITH ANY OTHER OFFER, DISCOUNT, PRESCRIPTION SAVINGS CARD, OR FREE TRIAL. Use of this card is subject to the program requirements, which can be found on the Janssen CarePath Savings Program Brochure.

By signing, dating, and submitting this form, you confirm that **you already enrolled in the Janssen CarePath Savings Program and activated your Savings Program card before receiving your Janssen medication. Janssen CarePath cannot process this rebate form if you have not completed this process.** In addition, you indicate you read, understand, agree, and meet the terms and conditions on this form, as well as the program requirements which were explained to you when you received the Savings Program card, which may also be found in the Janssen CarePath Savings Program Brochure.

*Patient Signature	*Date
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Site representative signature required ONLY if proof of payment is not provided with rebate request. By signing below, you are confirming the patient has paid for his/her out-of-pocket medication costs and was treated with STELARA® (J3357, J3358) on the date below.

*Site Representative Signature	*Print Name	*Date	
*Treatment Site Name/Location			*Date of Treatment

You can submit online, by fax, or by mail:



Online:
MyJanssenCarePath.com

Patient should only submit this form online if site representative signature is required for proof of payment.



Fax:
844-250-7193



Mail:
Janssen CarePath Savings Program
2250 Perimeter Park Drive, Suite 300
Morrisville, NC 27560

You will receive your rebate check in about three weeks.

Please read the full [Prescribing Information](#) and [Medication Guide](#) for STELARA®, and discuss any questions you have with your doctor.



Pharmacy Benefit Rebate Form

Complete this Pharmacy Benefit Rebate Form only if you are submitting a pharmacy receipt for a rebate check to be sent directly to the patient.

Receive a Rebate in 4 Easy Steps

- 1 The patient must be enrolled in the Janssen CarePath Savings Program before receiving a Janssen medication. Patient can enroll by calling 877-CarePath (877-227-3728) or online at MyJanssenCarePath.com.
- 2 Patient must complete the information below and sign the form.
- 3 Include a copy of the pharmacy receipt. Valid receipt will include patient name, medication (name, J code, or NDC#), date, and amount paid for patient's STELARA® medication.
If patient's receipt includes a prescription number and does not include Janssen medication name, also include a copy of patient's prescription label from the medication carton.
- 4 Submit for a rebate through your online account at MyJanssenCarePath.com OR submit this signed form by fax or by mail along with patient's pharmacy receipt and, if required, prescription label from medication carton (see below for details). A completed Rebate Form is not required if submitting rebate request online. Eligible patients will receive a rebate check in about three weeks.

If you are submitting an **Explanation of Benefits (EOB)** and want to receive a rebate check, only complete the Medical Benefit Rebate Form on the previous page.

Complete the information below. *Required

The information you provide will only be used by Janssen Biotech, Inc., our affiliates, and our service providers, to provide benefits to you related to your participation in the Janssen CarePath Savings Program for STELARA®. If you want to stop receiving this information or service, you may withdraw from the program by calling 877-CarePath (877-227-3728). Our [Privacy Policy](#) governs the use of the information you provide.

*Name	E-mail	*Phone	
			Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
*11-digit ID# found on the front of the savings card		*Date of Birth (mm/dd/yyyy)	
*Address	*City	*State	*ZIP

You may not seek payment for the value received from this program from any health plan, patient assistance foundation, flexible spending account, or healthcare savings account.

This program is only for people age 6 or older using commercial or private health insurance for their Janssen medication. This includes plans from the Health Insurance Marketplace. This program is not for people who use any state or federal government-funded healthcare program. Examples of these programs are Medicare, Medicaid, TRICARE, Department of Defense, and Veterans Administration.

You must meet the program requirements every time you use the program. Program terms will expire at the end of each calendar year. The program may change or end without notice, including in specific states. **To use this program, you must follow any health plan requirements, including telling your health plan how much co-payment support you get from this program. By getting a Savings Program benefit, you confirm that you have read, understood, and agree to the program requirements on this page, and you are giving permission for information related to your Savings Program transactions to be shared with your healthcare provider(s). These transactions include rebates and any funds placed on the card or balance remaining on the card.** Offer good only in the United States and its territories. Void where prohibited, taxed, or limited by law. REBATE FORM CANNOT BE BOUGHT, TRANSFERRED, OR SOLD. REBATE FORM CANNOT BE COMBINED WITH ANY OTHER OFFER, DISCOUNT, PRESCRIPTION SAVINGS CARD, OR FREE TRIAL. Use of this card is subject to the program requirements, which can be found on the Janssen CarePath Savings Program Brochure.

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*Patient Signature	*Date
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