# Johnson & Johnson Patient Assistance Program
# Patient Enrollment Form

**Submit completed enrollment form and supporting documents via ONE of the following:**

**Fax** 833-512-0497 **Upload** JJPatientAssistance.com/documents **Mail** J&J withMe
2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560

Johnson & Johnson believes that access and affordability challenges shouldn't stand in the way of patients and their medicines. Medicines from Johnson & Johnson may be provided at no cost to eligible patients who are uninsured or have inadequate coverage through commercial, employer group, or government insurance coverage and are not supported by other Johnson & Johnson offerings.

## Medicines available through this form

**CAPLYTA®†** (lumateperone) Capsules

**EDURANT®*** (rilpivirine) Tablets

**ELMIRON®*** (pentosan polysulfate sodium) Capsules

**INTELENCE®*** (etravirine) Tablets

**INVEGA HAFYERA®†** (paliperidone palmitate) Extended-release injectable suspension

**INVEGA SUSTENNA®†** (paliperidone palmitate) Extended-release injectable suspension

**INVEGA TRINZA®†** (paliperidone palmitate) Extended-release injectable suspension

**INVOKAMET®†** (canagliflozin/metformin HCl) Tablets

**INVOKAMET® XR†** (canagliflozin/metformin HCl) Extended-release tablets

**INVOKANA®*** (canagliflozin) Tablets

**PREZCOBIX®*** (darunavir/cobicistat) Tablets

**PREZISTA®*** (darunavir) Tablets or oral suspension

**RISPERDAL CONSTA®†** (risperidone) Long-acting injection

**SIRTURO®†** (bedaquiline) Tablets

**SPRAVATO®†** (esketamine) Nasal Spray CIII, for intranasal use

**SYMTUZA®†** (darunavir/cobicistat/emtricitabine/ tenofovir alafenamide) Tablets

**XARELTO®†** (rivaroxaban) Tablets or oral suspension

**YONDELIS®*** (trabectedin) Injection for intravenous use

*Please see Important Safety Information and full Prescribing Information available at **JNJwithMe.com** and available from your J&J representative.

†Please see Important Safety Information, including Boxed Warning(s), and full Prescribing Information available at **JNJwithMe.com** and available from your J&J representative.

### Patients' income must be equal to or less than 300% of Federal Poverty Level (FPL)

| Household/Family Size | 2026 Program Income Limit | | |
|---|---|---|---|
| | All states except Alaska and Hawaii | Alaska | Hawaii |
| 1 | $46,950 | $58,650 | $53,970 |
| 2 | $63,450 | $79,290 | $72,960 |
| 3 | $79,950 | $99,930 | $91,950 |
| 4 | $96,450 | $120,570 | $110,940 |
| Each person over 4, add | $16,500 | $20,640 | $18,990 |

**Questions?** Call **833-742-0791**, Monday–Friday, 8:00 AM–8:00 PM ET or visit **JJPatientAssistance.com**

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## Instructions for enrollment

### Enrollment Checklist

☐ Complete all sections and sign on page 4

Review pages 7–10 in their entirety. These pages contain the **Patient Consent Form**, which allows J&J to determine your eligibility and enroll you in the Johnson & Johnson Patient Assistance Program, and the **Patient Support Program Patient Authorization Form**, which gives your healthcare providers permission to use and share your medical information with the patient support programs offered by J&J. Please certify that you have read, understand, and agree by signing sections 3 and 4 on page 4.

You can also submit these forms online at:

- Patient Consent Form **JJPatientAssistance.com/Consent**
- Patient Authorization Form **JJPatientAssistance.com/PA**

If you have already completed a Patient Consent Form and Patient Authorization Form, you do not need to sign new forms.

☐ Ask your Healthcare Provider to complete pages 5 and 6 and sign page 6

☐ Gather any required supporting documents. Any required information you do not provide with your initial submission will cause delays in processing your application

### Supporting Documents

Best practice to include if you have the following:

☐ Insurance information: copies of the front and back of all insurance card(s) (eg, medical, pharmacy, etc, if you did not complete section 2 on page 3)

☐ Proof of income: a copy of your most recent 1040 or 1040-SR Federal tax return

☐ For Puerto Rico only: Please include financial documentation support with application submission. Acceptable forms include Income Tax Return (Form 482), Returns Filing Certification Form (Form AS 6088.1), or Social Security Benefits (SSA-1099)

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## To Be Completed by Patient

Fields marked with an (*) are required

### 1. PATIENT INFORMATION

*First Name _____ *Last Name _____ *Primary Phone _____

Email _____ *Date of Birth *(mm/dd/yyyy)* _____

*Address Line 1 _____ Address Line 2 _____

*City _____ *State _____ *ZIP Code _____

*Product Name _____

This is the address that all self-administered medicine will be shipped to. For a change of address, please contact 833-742-0791 and share the information with your Healthcare Provider.

### 2. INSURANCE INFORMATION *(Complete for all available insurance and submit copies of front and back of all insurance cards.)*

☐ I have no insurance and have checked eligibility requirements or applied to all available options for free or minimal cost insurance or other assistance.

If you were previously enrolled in a patient assistance program, please provide your patient ID # _____

**Primary Prescription Insurance (PPI)** _____ PPI Prescription Card BIN # _____ PPI Phone _____

PPI Cardholder Name (First, MI, Last) _____ PPI Cardholder Date of Birth _____

PPI Relationship to Cardholder _____

PPI Policy # _____ PPI Group # _____

**Primary Medical Insurance (PMI)** _____ PMI Phone _____

PMI Cardholder Name (First, MI, Last) _____ PMI Cardholder Date of Birth _____

PMI Relationship to Cardholder _____

PMI Policy # _____ PMI Group # _____

**Secondary Medical Insurance (SMI)** _____ SMI Phone _____

SMI Cardholder First Name (First, MI, Last) _____

SMI Relationship to Cardholder _____

SMI Policy # _____ SMI Group # _____

*Cardholder Employer Name _____ *Cardholder Employer Phone _____

*Cardholder Employer Address _____

*Cardholder Employer City _____ *Cardholder Employer State _____ *Cardholder Employer ZIP Code _____

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## To Be Completed by Patient

Fields marked with an (*) are required

### 3. PATIENT CONSENT FORM *(Please review Patient Consent Form on pages 7–8.)*

**My signature below certifies that I have provided accurate and complete information and that I have read, understood, and agree to the Patient Consent Form on pages 7–8. Your signature also allows Johnson & Johnson to perform a credit check. This will not impact your credit score.**

*Print Patient Name _____

*Patient or legally authorized representative† sign here _____ *Date _____

*†A Legally Authorized Representative is a person authorized, under state or other applicable law, to act on behalf of the individual in making healthcare-related decisions, such as a parent, guardian, or (court-appointed) representative.*

### 4. PATIENT AUTHORIZATION FORM CONSENT *(Please review Patient Authorization Form on pages 9–10.)*

**By signing below, I certify that I have read, understand, and agree to the Johnson & Johnson Patient Support Program Patient Authorization form on pages 9–10.**

*Print Patient Name _____

*Patient or legally authorized representative† sign here _____ *Date _____

*†A Legally Authorized Representative is a person authorized, under state or other applicable law, to act on behalf of the individual in making healthcare-related decisions, such as a parent, guardian, or (court-appointed) representative.*

*Describe relationship to patient and authority to make medical decisions for patient _____

### 5. OPTIONAL COMMUNICATIONS

#### Permission for communications outside of Johnson & Johnson's patient support programs

☐ **Receive personalized communications.**
Empower your journey with relevant information. Receive updates about disease education and J&J medicines.

☐ **Receive updates about other J&J medicines and resources.**
Receive information about other J&J medicines and resources.

#### Permission for text communications

☐ Yes, I would like to receive text messages. By selecting this option, I agree to receive text messages about the Johnson & Johnson Patient Assistance Program and any optional communications I select 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 Johnson & Johnson Patient Assistance Program or to receive any other communications I have selected.

Cell Phone Number _____

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## To Be Completed by Provider

Fields marked with an (*) are required

## 1. PRESCRIPTION

*Patient First Name _____ *Patient Last Name _____ *Patient Primary Phone _____

*Patient Address Line 1 _____ Patient Address Line 2 _____

*Patient City _____ *Patient State _____ *Patient ZIP Code _____

*Patient Date of Birth *(mm/dd/yyyy)* _____ Patient Weight _____ Patient Height _____ *Patient Sex _____

*ICD Code _____ Name of Product _____ *Strength _____

*Sig (Directions for use) _____

*Quantity _____ *Day Supply _____ *(**For tablet/capsule products:** Indicate 30- or 90-day supply; defaults to 90 days if left blank)*

First Time Fill: ☐ Yes ☐ No *Number of Refills *(maximum 11)* _____ *Need by Date _____

Additional Notes _____

_____

_____

***Ship to Location** ☐ **Patient Home** (same as above) ☐ **Prescriber Office** (same as section 2 on next page)

☐ **Treatment Center** (if different from Prescriber Office)

Complete this section **ONLY** if the location of treatment is a different address from the patient's home or your office.

Site Name _____ Site Contact Name for Shipment _____

Site Business Hours _____ Site Phone _____ Site Fax _____

Site Address Line 1 _____ Site Address Line 2 _____

Site City _____ Site State _____ Site ZIP Code _____

*Patient Allergies _____ or ☐ none

*List of Patient's Current Medicines _____ or ☐ none

For SPRAVATO® (esketamine): Due to the product being a controlled substance, an Rx cannot be captured in the Patient Enrollment Form. An electronic prescription must be sent to "*Wegmans Specialty Pharmacy #198*" directly from the HCP.

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## To Be Completed by Provider

Fields marked with an (*) are required

### 2. HCP INFORMATION *(The address you provide here will be used to ship HCP-administered medicines. Self-administered medicines will be shipped directly to the Patient.)*

*HCP First Name _____ *HCP Last Name _____ *HCP Site Name _____

HCP Site Contact _____ HCP Business Hours _____

*HCP Address Line 1 _____ HCP Address Line 2 _____

*HCP City _____ *HCP State _____ *HCP ZIP Code _____

*HCP Phone _____ *HCP Fax _____ HCP Email _____

*HCP Tax ID # _____ *HCP NPI # _____

HCP State License # _____ HCP Expiration *(mm/yyyy)* _____ HCP DEA # _____

*HCP Collaborating MD *(for mid-level providers)* _____ HCP Collaborating MD NPI # _____

HCP Provider Transaction Access Number (PTAN) *(required if the patient has Medicare)* _____

### 3. HCP AUTHORIZATION

The prescriber is responsible for ensuring the prescription complies with their state-specific prescription requirements, such as e-prescribing, state-specific prescription form, or fax language. Noncompliance with state-specific requirements could result in outreach to the prescriber.

**My signature below indicates that I have read, understand, and agree to the Johnson & Johnson Health Care Systems Inc. policy and the terms of Program participation.**

| HCP SIGN & DATE | *Healthcare Provider Signature _____ *HCP Authorization Date (*mm/dd/yyyy*) _____ |
|---|---|

**Questions?** Call **833-742-0791**, Monday–Friday, 8:00 AM–8:00 PM ET or visit **JJPatientAssistance.com**



Clear Form Print Form

# Patient Consent Form

## Why should I sign this form?

This form allows J&J to determine your eligibility and enroll you in the Johnson & Johnson Patient Assistance Program.

## Terms of Participation

I understand that Johnson & Johnson Health Care Systems Inc. (JJHCS) and third parties associated with administrating the Program on behalf of JJHCS (collectively, the "Program Administrators"):

- Reserve the right without notice to change the application form, change the Program or Program criteria, or to terminate my enrollment at any time;
- May request and obtain information about my or my family's income, including verification of my income, or my insurance coverage, including documentation of any insurance denials, and that the information may be requested from me, others acting on my behalf or third-party sources;
- May request that I re-verify my eligibility to receive medicines under the Program

### I certify that:

- All the information on this form and all the documentation submitted are complete and correct, and to the best of my knowledge, I meet the eligibility requirements for the submission of the application
- I am completing this application voluntarily. I have not been directed by my insurance company or by a non-medical professional to complete this application. I have not been offered any financial or other benefit by any third party in order to seek assistance from JJHCS and I have not been told that any benefit will be denied or withheld (such as insurance coverage) if I do not complete this application
- I have completed this application myself or with the assistance of a legally authorized representative (such as a guardian), family member, caregiver, friend, healthcare provider, or representative of a patient organization. If such assistance was provided, I have reviewed the application before submission to JJHCS to ensure all information is accurate and true. No other third party has assisted with the completion of this application
- The product(s) provided under this patient assistance program will not be sold or traded
- I will notify the Johnson & Johnson Patient Assistance Program within thirty (30) days if there is any change in my income or health insurance coverage. This includes a change in my eligibility to participate in the Medicare program due to changes in my age or disability status or my enrollment in Medicare Part D
- I will not attempt to claim or submit any costs associated with the medicine(s) I receive under the Johnson & Johnson Patient Assistance Program to any person or entity, including my Medicare Part D plan
- I will not seek true out-of-pocket (TrOOP) credit under the Medicare Part D program for the cost of the medicine(s) I receive under this program

## Terms & Conditions

You may be eligible to receive your medicine(s) from J&J at no cost for up to one year if you have been prescribed a medicine from J&J, have a financial hardship, and have exhausted all other affordability options.

You must meet the eligibility and income requirements to qualify for the Johnson & Johnson Patient Assistance Program.

You are not eligible for medicine from J&J at no cost if your health insurance will cover the cost of your prescribed medicine from J&J if this application is denied. Some employers, insurers, and other companies force patients to apply for medically necessary medicines from free product programs instead of covering such medicines directly and immediately through insurance, which could lead to delays in care and discriminate against lower-income patients. These types of "Assistance Diversion Programs" are generally established by companies that profit by diverting resources away from patients in need. An Assistance Diversion Program is any insurer, employer, or third-party program that withholds coverage or payment for Patient's medically necessary drug until Patient has completed an application for free product assistance. Assistance Diversion Programs are prohibited by Johnson & Johnson (J&J) to make sure that help is available for patients with no safety net in place. Your insurer must submit a Patient Eligibility Certification form to confirm that your drug coverage is not subject to an Assistance Diversion Program.

The Johnson & Johnson Patient Assistance Program does not replace products that were administered or dispensed to eligible and enrolled patients from provider supply or provider-affiliated pharmacy supply.



continued next page

# Patient Consent Form

## Terms & Conditions (cont'd)

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

Before you enroll in the patient assistance program, it is important you understand that you will be asked to provide personal information that may include your name, address, phone number, email address, financial information, and/or other information, including information related to your prescription medicine insurance and treatment. This information will be used by Johnson & Johnson Health Care Systems Inc. (JJHCS) and its service providers to determine your eligibility for, enroll you in, and administer the program. The use of your information will be governed by our **Privacy Statement**.

If you have Medicare Prescription Drug Coverage (Part D) and your income is equal to or less than 150% of the Federal Poverty Level (FPL), you will need to demonstrate that you are not eligible for the Low-Income Subsidy (LIS).

This program offer may not be used with any other coupon, discount, prescription savings card, free trial, or other offer. Offer good only in the United States, Puerto Rico, and the US Virgin Islands, which includes St. Thomas, St. John, and St. Croix. Void where prohibited, taxed, or limited by law. Program terms will expire at the end of each calendar year and may change or end without notice, including in specific states.

You may end your participation in the program at any time by calling 833-742-0791, Monday through Friday, 8:00 AM to 8:00 PM ET.

**Your agreement to this Patient Consent Form is captured on page 4 section 3.**

# Patient Support Program Patient Authorization Form

## Why should I sign this Form?

This Form gives your Healthcare Providers permission to use and share your medical information with the patient support programs offered by Johnson & Johnson.

## Section 1 What health information am I sharing and with whom?

I give permission for my Healthcare Providers and Insurers (eg, my health insurance plans) to share my Protected Health Information, as described on this Form.

**My Protected Health Information includes information related to:** my medical condition, treatment, prescriptions, and health insurance coverage

**My Healthcare Providers may include:** physicians, pharmacists, specialty pharmacies, other healthcare providers, and staff members at my healthcare providers' offices

I give permission to these people or groups to receive and use my Protected Health Information (collectively "J&J"):

- Johnson & Johnson Health Care Systems Inc., its affiliated companies, agents, and representatives
- Providers of other sources of funding. This includes foundations and co-pay assistance providers
- Service providers for the patient support programs. This includes subcontractors or healthcare providers helping J&J run the programs
- Service providers maintaining, transmitting, de-identifying, aggregating, or analyzing data from J&J's support programs

**My Protected Health Information may be shared by J&J with these people and groups:** my Insurers, my Healthcare Providers, any other people given permission to receive and use my Protected Health Information (as mentioned above), anyone I give permission to as an additional contact, and service providers who review data from J&J's patient support programs

**J&J and the other groups on this Form may share information about me in 2 ways:** as permitted on this Form, and if any information that identifies me is removed from what has been shared

## Section 2 How can giving permission help with patient support programs and access?

I give permission to J&J to receive, use, and share my Protected Health Information to:

- See if I qualify for, sign me up for, contact me about, and provide services relating to J&J's patient support programs. This includes in-home services
- Manage J&J's patient support programs
- Give me resources and information related to my J&J medicine in connection with J&J's patient support programs. This includes educational and adherence materials
- Communicate with my Healthcare Providers about access, reimbursement, and fulfillment for my J&J medicine
- Inform my Healthcare Provider that I am enrolled in J&J's patient support programs
- Help verify and coordinate coverage for J&J medicines with my Insurers and Healthcare Providers
- Help with prescription or treatment location and associated scheduling
- Conduct analysis to help J&J evaluate, create, and improve their patient support services and products for patients prescribed J&J medicines
- Share information from J&J's patient support programs that may be useful for my care

## Section 3 What should I understand before signing this Form?

I understand that:

J&J will use reasonable efforts to keep my information private. But, once my Protected Health Information is disclosed as allowed on this Form, it may no longer be protected by federal privacy laws

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 in or receive assistance from J&J's patient support programs

The following groups may be paid by J&J for their services and data, including Protected Health Information:

- Pharmacies that dispense and ship my medicine
- Service providers for J&J's patient support programs

This Form will remain in effect 10 years from the date I signed, except if:

- State law requires a shorter time or
- I am no longer in any patient support program from J&J

Information collected before that date may continue to be used for the purposes noted in this Form

- I may cancel the permissions given by this Form at any time by letting J&J know in writing at J&J withMe, 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 J&J
- If I cancel my permission, it will not affect how J&J uses and shares my Protected Health Information received by J&J before my cancellation
- I may request a copy of this Form

**Your agreement to this patient support program patient authorization form is captured on page 4 section 4.**

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