Tremfya withMe

Savings Program
833-WITHME1 (833-948-4631)
Monday–Friday, 8:00 AM–11:00 PM ET

Tremfya® (guselkumab)

Medical Benefit Rebate Form

Complete this side of the 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 TREMFYA withMe Savings Program before receiving TREMFYA®. You or the patient can enroll by calling 833-WITHME1 (833-948-4631) or online at **Account.JNJwithMe.com**.
2. Patient or patient's legally authorized representative 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 TREMFYA® costs. A valid receipt will include patient name, medicine (name, J code, or NDC#), date, and amount of out-of-pocket responsibility paid for 1) patient's medicine and 2) if patient has been prescribed a TREMFYA® infusion, eligible administration and laboratory tests.

   If patient does not have proof of payment for the submitted claim, patient must obtain their site representative's signature below.
4. Submit this form online or by fax 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. Rebate requests must be submitted within 365 days of the date of service.

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 Johnson & Johnson Health Care Systems Inc., our affiliates, and our service providers to provide benefits to the patient related to participation in the TREMFYA withMe Savings Program. If you want to stop receiving this information or service, you may withdraw from the program by calling 833-WITHME1 (833-948-4631). Our Privacy Policy governs the use of the information you provide. By participating in the TREMFYA withMe Savings Program, you are giving permission for information related to your Savings Program transactions, including rebates and any funds placed on or balance remaining on the Savings Program card, to be shared with your healthcare provider(s).

☐ By providing consent, you agree to the collection and use of your/the patient's Sensitive Personal Information (SPI). Examples of SPI may include, but are not limited to, health-related information. We use this information consistent with our Privacy Policy, including to personalize the information you receive, fulfill any requests you submit, and to research, develop, and improve our products and services. By checking the box, you indicate that you read, understand, and agree to such collection and use of your/the patient's SPI.

*Name _____ E-mail _____ *Phone _____

*Medical Claims ID # found on the front of the savings card _____ *Date of Birth (mm/dd/yyyy) _____ Sex ☐ Male ☐ Female

*Address _____ *City _____ *State _____ *ZIP _____

This program is only for people who are prescribed TREMFYA® for an FDA-approved indication, using commercial or private health insurance who must pay an out-of-pocket cost for their TREMFYA® medicine, eligible laboratory tests, and/or TREMFYA® infusion administration. 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 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.

You/the patient must meet the program requirements every time you use the Savings Program. Program terms will expire at the end of each calendar year. The program may change or end without notice, including in specific states. Treatment Administration Cost Support is not valid for residents of MA, MN, or RI. Program participants are subject to an annual maximum benefit. Program benefits are set at the discretion of Johnson & Johnson and may change without notice.

To use this program, you must follow any health plan requirements, including telling your health plan how much co-payment support you get/the patient gets from this program, if required. By using the Savings Program, you confirm that you have read, understood, and agree to the program requirements, and you are giving permission for information related to your Savings Program transactions to be shared with your/the patient's 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, excluding states noted above. 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 program is subject to the program requirements, which can be found at **TREMFYAwithMeSavings.com**.

By signing, dating, and submitting this form, you confirm that the patient:

- **has enrolled in the TREMFYA withMe Savings Program and received the savings card. Note: TREMFYA withMe cannot process this rebate form if you have not yet received your Savings Program card; and**
- meets the program requirements of the Savings Program, which may also be found at **TREMFYAwithMeSavings.com**

*Patient Signature (If the patient cannot sign, patient's legally authorized representative must sign below) _____ Patient Name (Please print) _____ *Date _____

Legally Authorized Representative Signature _____ Representative Name (Please print) _____ Date _____

Relationship to patient and authority to make medical decisions for patient

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 medicine costs and was treated with TREMFYA® (J1628) on the date below.

*Site Representative Signature _____ *Site Representative (Print name) _____ *Date _____

*Treatment Site Name/Location _____ *Date of Treatment _____

You can submit online or by fax:

Online Account: Account.JNJwithMe.com

Online: Account.JNJwithMe.com/submit-rebate

Fax: 833-512-0495

A completed rebate form is not required if submitting rebate request online.

You will receive your rebate check in about three weeks.

Please read the full Prescribing Information and Medication Guide for TREMFYA® and discuss any questions you have with your doctor.

 09/25 cp-451285v3

Clear Form Print Form

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Pharmacy Benefit Rebate Form

Complete this side of the 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 TREMFYA withMe Savings Program before receiving TREMFYA®. You or the patient can enroll by calling 833-WITHME1 (833-948-4631) or online at **Account.JNJwithMe.com**.
2. Patient or patient's legally authorized representative must complete the information below and sign the form.
3. Include a copy of the pharmacy receipt. A valid receipt will include patient name, medicine (name, J code, or NDC#), date, and amount paid for patient's TREMFYA® medicine.

   If patient's receipt includes a prescription number and does not include TREMFYA®, also include a copy of patient's prescription label from the medicine carton.
4. Submit for a rebate online or by fax along with patient's pharmacy receipt and, if required, prescription label from medicine 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. Rebate requests must be submitted within 365 days of the date of service.

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.

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*Name _____ E-mail _____ *Phone _____

*Pharmacy Claims ID # found on the front of the savings card _____ *Date of Birth (mm/dd/yyyy) _____ Sex ☐ Male ☐ Female

*Address _____ *City _____ *State _____ *ZIP _____

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