J&J withMe UPDATE 01.25

# Patient Enrollment Form

Simponi ARIA golimumab for infusion | Remicade INFLIXIMAB | Infliximab

**Complete and fax this Form to 866-489-5955. All fields are required unless marked optional. For assistance, prescribers can call 877-227-3728, Monday–Friday, 8:00 AM–8:00 PM ET.**

**A completed Patient Authorization Form, found on pages 3 and 4 of this document, is necessary to access certain patient support under J&J withMe. Please have your patient sign the Patient Authorization Form and submit with this completed Patient Enrollment Form.** The information you provide will be processed by Johnson & Johnson Health Care Systems Inc. and its service providers in accordance with its Privacy Policy and, if applicable, its affiliated, noncommercial dispensing pharmacy, Access Therapy Center ("Pharmacy"), in accordance with its Notice of Privacy Practices.

## Comprehensive support to help your patients start and stay on prescribed treatment

We will verify insurance coverage, support and monitor the prior authorization process, provide reimbursement information, help find affordability options for eligible patients, and provide ongoing support to help patients start and stay on medicines from J&J. **Johnson & Johnson Patient Assistance Program:** If your patient is uninsured or if their coverage does not fully meet their needs, they may be eligible to receive their medicine from J&J at no cost for up to one year. Your patient must meet the eligibility and income requirements for the Johnson & Johnson Patient Assistance Program. See terms and conditions at PatientAssistanceInfo.com/IMM. To have your patient enrolled in the Johnson & Johnson Patient Assistance Program if they are eligible, a SIMPONI ARIA®, REMICADE®, or Infliximab prescription is required in section 5.

## 1. PATIENT INFORMATION

NAME (First, MI, Last) _____ DOB (MM/DD/YYYY) _____ SEX ☐M ☐F

ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMAIL _____

PHONE _____ BEST TIME TO CONTACT ☐Morning ☐Afternoon ☐Evening

☐ The patient has consented to treatment by the Pharmacy and has authorized the collection, use, and disclosure of their health information as described in the Privacy Policy. I understand that the Pharmacy may be contacting the patient by phone or otherwise concerning this program.

## 2. INSURANCE INFORMATION

Provide a copy of the front and back of insurance cards. (If providing copy of insurance card, skip to section 3.)

☐ The patient has no insurance and has checked eligibility requirements or applied to all available options for free or minimal cost insurance or other assistance. If the patient was previously enrolled in a patient assistance program, please provide the patient ID #: _____

**PRIMARY INSURANCE** _____ CARDHOLDER _____

RELATIONSHIP TO CARDHOLDER _____ EMPLOYER _____ INS. CO. PHONE _____

POLICY # _____ GROUP # _____

**SECONDARY INSURANCE** _____ CARDHOLDER _____

RELATIONSHIP TO CARDHOLDER _____ EMPLOYER _____ INS. CO. PHONE _____

POLICY # _____ GROUP # _____

**PRESCRIPTION DRUG INSURER** _____ CARD/BIN # _____ PHONE _____

☐ Is patient a dependent of the insured (child <18 years; student >18 years)? Check if yes.

## 3. PRESCRIBER INFORMATION

PRESCRIBER NAME (First, Last) _____

SPECIALTY _____

PRACTICE NAME _____ OFFICE CONTACT _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

EMAIL _____ PHONE _____ FAX _____

MEDICAID/MEDICARE PROVIDER # _____ TAX ID # _____

STATE LICENSE # _____ UPIN/NPI # _____

**Are you the prescribing specialist?** (Required) ☐YES ☐NO IF NO, REFERRING SPECIALIST _____

REFERRING PHYSICIAN SPECIALTY _____

## 4. PRIOR MEDICINES (Specify—P=Prior, C=Current, F=Failure)

☐ Acetaminophen, ibuprofen, naproxen sodium, or other over-the-counter pain relievers _____

| | | | |
|---|---|---|---|
| ☐ 5-ASA _____ | ☐ Celebrex® _____ | ☐ Gold compounds _____ | ☐ Methotrexate _____ |
| ☐ 6-MP _____ | ☐ Cimzia® _____ | ☐ Humira® _____ | ☐ Orencia® _____ |
| ☐ Actemra® _____ | ☐ Corticosteroids _____ | ☐ Hydroxychloroquine _____ | ☐ Penicillamine _____ |
| ☐ Azathioprine _____ | ☐ Cyclophosphamide _____ | ☐ Indocin® _____ | ☐ Rituxan® _____ |
| ☐ Azulfidine® _____ | ☐ Cyclosporine _____ | ☐ Kineret® _____ | ☐ Other _____ |
| ☐ Calcipotriene _____ | ☐ Enbrel® _____ | ☐ Leflunomide _____ | |

## 5. PRESCRIPTION INFORMATION

**Visit JNJwithMe.com for ICD-10 codes or consult the ICD-10 code book for additional information.**

(If patient qualifies for and enrolls in Delay & Denial Support or Johnson & Johnson Patient Assistance Program, this prescription will be used by the Access Therapy Center [noncommercial pharmacy] to dispense the patient's SIMPONI ARIA®, REMICADE®, or Infliximab.)

☐ **SIMPONI ARIA® 50 mg/4 mL** DIAGNOSIS CODE _____ INDICATION _____

**For adult patients with moderately to severely active rheumatoid arthritis, active psoriatic arthritis, and active ankylosing spondylitis**

DOSING/FREQUENCY: 2 mg/kg at weeks 0 and 4, and every 8 weeks thereafter (The dosage regimen is based on the patient's body surface area [BSA]).

**For pediatric patients 2 years of age and older with active polyarticular juvenile idiopathic arthritis (pJIA) and active psoriatic arthritis (PsA)**

DOSING/FREQUENCY: 80 mg/m$^2$ at weeks 0 and 4, and every 8 weeks thereafter (The dosage regimen is based on the patient's body surface area [BSA]).

NUMBER OF PRIOR SIMPONI ARIA® INFUSIONS ☐ unknown ☐ 0 ☐ 1-3 ☐ 4+

☐ Induction: Infuse _____ mg IV at weeks 0, 4 Vials # (for 1 infusion) _____ Refills # 2

☐ Maintenance: Infuse _____ mg IV every 8 weeks thereafter Vials # (for 1 infusion) _____ Refills # _____

☐ **REMICADE® or ☐ Infliximab** DIAGNOSIS CODE _____ INDICATION _____

☐ Induction: Infuse _____ mg IV at weeks 0, 2, 6 Vials # (for 1 infusion) _____ Refills # 2

☐ Maintenance: Infuse _____ mg IV every _____ weeks thereafter Vials # (for 1 infusion) _____ Refills # _____

## PRESCRIPTION

**Signature required to enroll eligible patients in Johnson & Johnson Patient Assistance Program.**

By submitting this prescription, I understand the Pharmacy will check the patient's eligibility for and may enroll the patient in certain support programs based on the results of the benefits investigation with patient consent. If the patient is eligible for support programs, I certify that I agree to the programs' requirements and will take the necessary actions described in the requirements for the patient. See program requirements on next page.

PRESCRIBER SIGNATURE (Dispense as written) _____ DATE _____

## 6. PREFERRED SITE OF INFUSION

**(Fields below do not need to be completed if information is the same as in the Prescriber Information section)**

☐ 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 # _____

**Please see the full Prescribing Information, including Boxed Warning, and Medication Guides for SIMPONI ARIA®, REMICADE®, and Infliximab.**

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The patient support and resources provided by J&J withMe are not intended to give medical advice, replace a treatment plan from the patient's healthcare provider, offer services that would normally be performed by the provider's office, or serve as a reason to prescribe a J&J medicine.

Information about your patient's insurance coverage, cost support options, and treatment support is given by service providers for J&J withMe. The information you get does not require you or your patient to use any Johnson & Johnson product. Because the information we give you comes from outside sources, J&J withMe cannot promise the information will be complete.

## JOHNSON & JOHNSON PATIENT ASSISTANCE PROGRAM

Patient assistance is available if your patient is uninsured, or has commercial, employer-sponsored, or government coverage that does not fully meet their needs. Your patient may be eligible to receive their medicine from J&J at no cost for up to one year if they meet the following requirements:

- Your patient is uninsured or has a commercial or employer-sponsored insurance plan or government coverage, such as Medicare, Medicaid, TRICARE, U.S. Department of Veterans Affairs health care, or U.S. Department of Defense health care
- Your patient lives in the United States or a U.S. territory
- Your patient is treated as an outpatient by a healthcare provider licensed in the U.S.
- Your patient has been prescribed an eligible medicine from J&J
- Your patient meets the income eligibility requirements
- **For Medicare Part D Patients Only:**
  - Your patient demonstrates they are not eligible for the Low-Income Subsidy (LIS)
  - Your patient spends more than 4% of their gross annual household income on prescription drugs

To learn more about income requirements, terms & conditions, and how to enroll your patient in the Johnson & Johnson Patient Assistance Program, please visit **PatientAssistanceInfo.com/IMM** or call 877-227-3728.

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# 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

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## 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 below, 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, PO Box 15510, Pittsburgh, PA 15244
  - 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

*For privacy rights and choices specific to California, Colorado, Connecticut, Utah, Virginia, and Washington residents, please see J&J's US Supplemental Privacy Notice available at* ***InnovativeMedicine.JNJ.com/us/privacy-policy#supplemental***

## Section 4 Fill in Personal Information & Sign Patient Authorization Form

Patient name (print) _____

Email Address _____

Patient sign here _____ Date _____

If patient cannot sign, patient's legally authorized representative must sign below:

By _____ Print name _____ Date _____

(Signature of person legally authorized to sign for patient)

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

_____

## Optional Resources

Permission for communications outside of J&J's patient support programs:

☐ Yes, I would like to receive communications about my J&J medicine

☐ Yes, I would like to receive communications about other products and services from J&J

Permission for text communications:

☐ Yes, I would like to receive text messages. By selecting this option, I agree to receive text messages as allowed by this Form 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 J&J's patient support programs or to receive any other communications I have selected. Cell phone number: _____

**Sign and return this Form to:**

Fax to: 866-489-5955

J&J withMe, PO Box 15510, Pittsburgh, PA 15244

**Or, eSign a digital Form:**

In your healthcare provider's office

At **Account.JNJwithMe.com**

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