J&J

withMe

Guide to Completing the Patient Authorization

Once you and your healthcare provider have decided that an oral PAH medicine from Johnson & Johnson is right for you, J&J withMe will help you find the resources you may need to get started and stay on track. We will give you information on your insurance coverage, potential out-of-pocket costs, and treatment support, and identify options that may help make your treatment more affordable. **Completing the Patient Authorization Form gives your healthcare providers permission to use and share your medical information with the patient support programs offered by Johnson & Johnson, including J&J withMe.**

This section explains the purpose of the Patient Authorization Form.

Johnson & Johnson

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

This section describes the people or groups that may receive and use your PHI.

Section 2 outlines the purposes for which J&J may receive, use, and share your PHI.

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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Guide to Completing the Patient Authorization (cont'd)

⚠ **IMPORTANT:** Please read and note that you are not required to sign this form.

Please complete all fields. Your name, email, and contact information are needed to ensure we can reach you with program updates.

⚠ **IMPORTANT:** Remember to sign and date the form so that J&J withMe can start providing you with support.

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, 6931 Arlington Road, Suite 400, Bethesda, MD 20814
  - 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

You may cancel your Authorization at any time by following the cancellation instructions.

Section 4 Fill in Personal Information & Sign Patient Authorization Form

Patient name (print) _____ **DOB** *(mm/dd/yyyy)* _____

Email Address _____ **Phone Number** _____

Patient Address _____

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

Patient signature _____ **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:

_____

See page 3 for helpful resources and instructions for completing and returning this Form. ▼

Please visit **JNJwithMe.com** for information about J&J's patient support programs

Data rates may apply.

You can visit **JNJwithMe.com** at any time for more information.

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Guide to Completing the Patient Authorization (cont'd)

(Optional) You may find it helpful to receive additional educational and informational resources from Johnson & Johnson:

- Check the first box to authorize J&J to send you updates related to your prescribed medicine
- Check the second box to authorize J&J to send you communications relating to other products and services offered by J&J including other PAH products and services from J&J

Please note that you may call J&J withMe at any time with questions or to opt out of the communications described.

You may submit the Patient Authorization one of two ways:

- Fill out a printed form and send to J&J withMe by fax or mail
- Complete online at **PAHconsent.com**

Helpful resources you can sign up for (optional)

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: _____

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***

How to Complete and Return the Patient Authorization Form

Sign and return pages 1 and 2 of this Form to: (If optional resources are selected, complete and return page 3)

Fax to: 866-279-0669

J&J withMe
6931 Arlington Road, Suite 400
Bethesda, MD 20814

Or, eSign a digital Form:

In your healthcare provider's office

At **PAHconsent.com** or scan this QR code

Data rates may apply.

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(Optional) To receive support, reminder, and educational text messages from J&J withMe, check the box and provide your cell phone number.

For example, checking this box allows patient support teams from J&J to let you know via text message that they'll be contacting you by phone, so you will know to expect their call.

Need help?

If you have any questions, contact

J&J withMe at 866-228-3546

Monday through Friday, 8:00 AM to 8:00 PM ET

Johnson&Johnson