


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
- Service providers for the patient support programs. This includes subcontractors or healthcare providers helping J&J run the programs
- Providers of other sources of funding. This includes foundations and co-pay assistance providers
- 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
- Inform my Healthcare Provider that I am enrolled in J&J's patient support programs
- Manage J&J's patient support programs
- Help verify and coordinate coverage for J&J medicines with my Insurers and Healthcare Providers
- 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
- Help with prescription or treatment location and associated scheduling
- Communicate with my Healthcare Providers about access, reimbursement, and fulfillment for my J&J medicine
- 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 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

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.



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](https://www.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](https://www.PAHconsent.com) or scan this QR code



Data rates may apply.