J&J
withMe

RYBREVANT®
(amivantamab-vmjw)
Injection for IV Use | 350 mg/7 mL (50 mg/mL)

Help your patients manage their Savings Program Benefits

- Submitting a rebate request to the J&J withMe Savings Program can be achieved in 2 ways:
  - the patient who is responsible can submit the rebate request, or
  - the patient may direct the provider to submit the rebate request on their behalf
- Please confirm with your patient who will submit the rebate requests to the Savings Program

NOTE: Rebate request must be submitted within 270 days of the date of service

The rebate payment is based on your patient's preferred payment method:

- To have your patient receive a **rebate by check**, submit a copy of their Explanation of Benefits (EOB) from their primary insurance provider (as well as any secondary insurance provider, if applicable) and a receipt from their treatment provider indicating proof of payment of their out-of-pocket medicine costs
- To have your patient receive the **rebate payment via their Virtual Payment Card**, submit a copy of only the patient's EOB from their primary insurance provider (as well as any secondary insurance provider, if applicable) indicating patient responsibility for their RYBREVANT® medicine costs

  NOTE: Patients may also submit rebate requests to the Savings Program online at **Account.JNJwithMe.com/submitrebate**, by fax, or by mail
- To receive **payment directly on behalf of your patient**, you will need to submit a copy of their EOB from their primary insurance provider (as well as any secondary insurance provider, if applicable) indicating patient responsibility for their RYBREVANT® medicine costs, and either a CMS-1500 (HICF) or Uniform Billing Form—CMS-1450 (UB-04). A signed Patient Assignment of Benefits (AOB) must also be on file

  NOTE: Please ensure that your patient has completed an AOB form and that you have faxed the AOB form to the fax number found on the form, in order for J&J withMe to process a rebate claim and provide payment directly to your site. The AOB form can be found at **JNJwithMe.com/hcp/Rybrevant** or by calling J&J withMe at 833-JNJ-wMe1 (833-565-9631)

Submitting a primary claim:

To submit a **primary claim** on behalf of the patient, providers must submit a CMS-1500 (HICF) or Uniform Billing Form—CMS-1450 (UB-04)—**through their electronic billing system**.

Submitting a secondary claim–for payment to you by EFT or check:

1. If you have submitted a primary claim and the claim has a remaining balance of $0 or more, you may submit a secondary claim.
   - Before you get started, contact your clearinghouse to request that Payer ID# 56155 be added to their system, if needed
2. Submit **secondary claim** to the J&J withMe Savings Program via the Provider Portal or fax (833-512-0489) using CMS-1500 or UB-04 medical claim forms or electronic versions 837P or 837I (electronic submission is preferred).
   - You will need to submit the primary payer EOB along with the secondary claim form
   - To complete the form, you will need the patient's J&J withMe Savings Program Member ID, Group# 00003651, and Payer ID# 56155
   - You will receive funds for approved claims by check, which will include information on setting up future payments via electronic funds transfer (EFT), if preferred
     - NOTE: If you already receive funds via EFT, you will continue to receive payments that way

See following pages for sample CMS-1500 and UB-04 claim forms with additional information.

Please read the full **Prescribing Information** for RYBREVANT®.

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Sample CMS-1500 Claim Form
for Billing in the Physician Office

1 Insured's ID Number
Enter the J&J withMe Savings Program Member number

2 Insured's Name
Enter the patient's name, even if patient is not the policyholder

3 Procedures, Services, or Supplies
Enter the NDC number in the shaded area and enter the appropriate J-Code, S-Code, or G-Code

NOTE:
Fill out the remainder of the CMS-1500 claim form the same way you would for a typical secondary claim submission. Please make sure the claim documentation clearly states the CPT/J-Code or S-Code and the NDC and/or drug name. For payers that require the G-Codes, enter the applicable code based on the dose of RYBREVANT®.

Use of the electronic version of the CMS-1500 (837P) is preferred.

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) | MEDICAID (Medicaid#) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 12345A67B

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe, John B.

3. PATIENT'S BIRTH DATE: 07 01 70 | SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Doe, John B.

5. PATIENT'S ADDRESS (No., Street): 3914 Spruce Street

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 3914 Spruce Street

CITY: Anytown | STATE: AS

8. RESERVED FOR NUCC USE

CITY: Anytown | STATE: AS

ZIP CODE: 01010 | TELEPHONE (Include Area Code): (203) 555-1234

ZIP CODE: 01010 | TELEPHONE (Include Area Code): (203) 555-1234

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M [ ] F [ ]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Dr. Jones

17a.

17b. NPI 123 456 7890

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): RYBREVANT® (amivantamab-vmjw) 2 mg injection

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.
A. C34.30 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	04 01 24	04 01 24	11		57894-0501-01 J9061	A		525		NPI	123 456 7890
2	04 01 24	04 01 24	11		96413	A		1		NPI	123 456 7890
3	04 01 24	04 01 24	11		96415	A		3		NPI	123 456 7890
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
a. b.

33. BILLING PROVIDER INFO & PH # (203) 987-6543
Dr. Jones
4231 Center Road
Anytown, AS 01010
a. 123 456 7890 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org *PLEASE PRINT OR TYPE* OMB APPROVAL PENDING

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Sample UB-04 Claim Form

for Billing in the Hospital Outpatient Department (HOPD)

1 Value Codes
Enter "PR2" under "Code" and enter the remaining patient responsibility after processing of the primary insurance claim under "Amount"

2 HCPCS/Rate/ HIPPS Code
Enter the appropriate J-Code, S-Code, or G-Code

3 Payer Name
Enter "J&J withMe Savings Program"

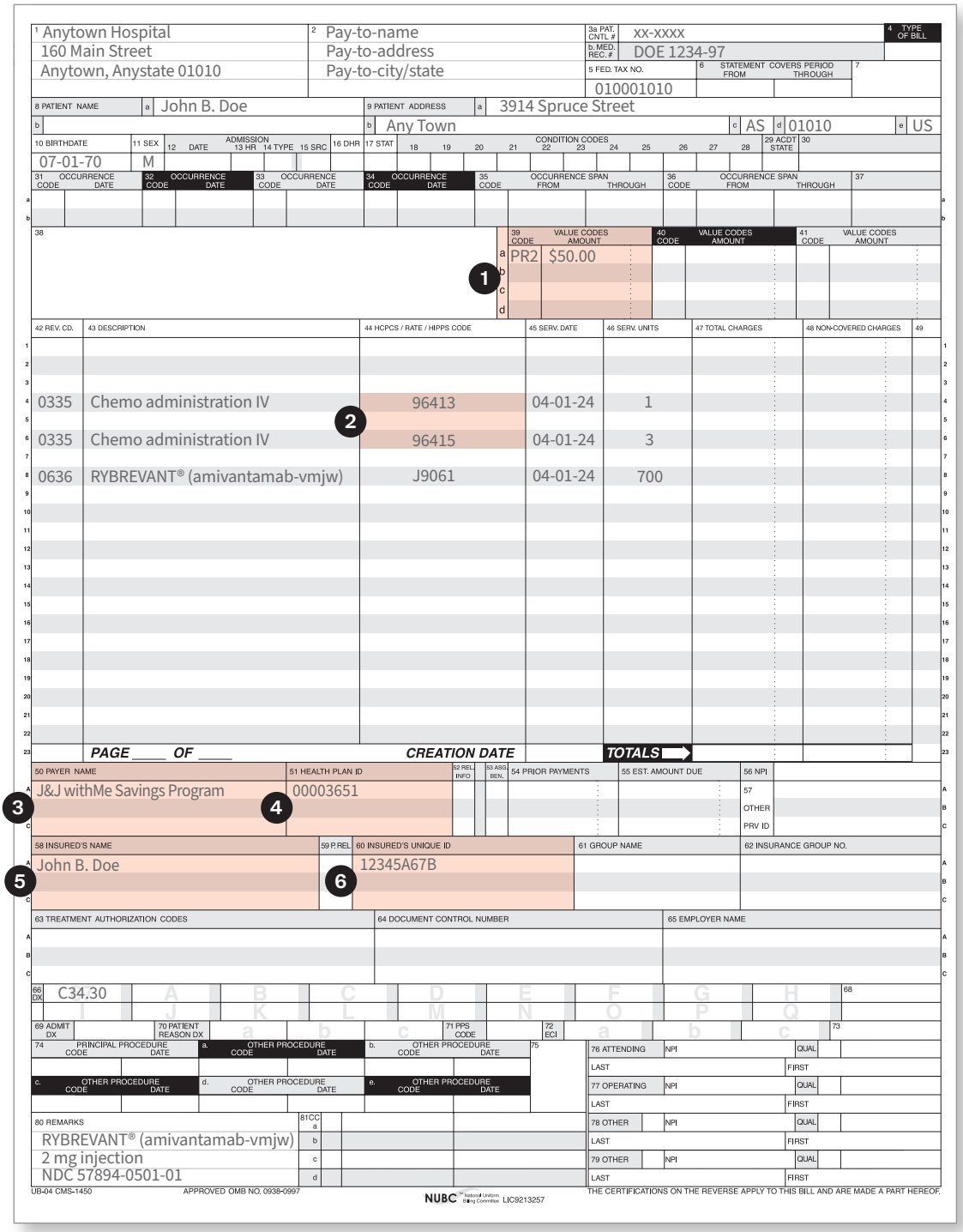
4 Health Plan ID
Enter the Group number: 00003651

5 Insured's Name
Enter the patient's name, even if patient is not the policyholder

6 Insured's Unique ID
Enter the J&J withMe Savings Program Member number

NOTE:
Fill out the remainder of the UB-04 claim form the same way you would for a typical secondary claim submission. Please make sure the claim documentation clearly states the CPT/J-Code or S-Code and the NDC and/or drug name. For payers that require the G-Codes, enter the applicable code based on the dose of RYBREVANT®.

Use of the electronic version of the UB-04 (837I) is preferred.



If you have questions about payment processing, call us at 833-JNJ-wMe1 (833-565-9631).

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J&J withMe is your single source for access, affordability, and treatment support programs from J&J. Your patients will be connected to RYBREVANT withMe.

Access support
to help navigate payer processes

Affordability support
to help patients discover ways to afford their J&J treatment

Dedicated 1-on-1 Care Connector
to support the nonclinical needs that may arise while on their J&J medicine

Single, dedicated Care Connector team supporting you and your patients

Sign up or log in to the Provider Portal at
Portal.JNJwithMe.com

Visit us online at
JNJwithMe.com

Questions?
Call **833-JNJ-wMe1** (833-565-9631)
Monday–Friday, 8:00 AM–8:00 PM ET
Multilingual phone support available

Bookmark these links for quick and easy access!

The patient support and resources provided by J&J withMe are not intended to provide medical advice, replace a treatment plan from the patient's doctor or nurse, provide case management services, or serve as a reason to prescribe a J&J medicine.

Please read the full **Prescribing Information** for RYBREVANT®.

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