J&J withMe

# Gastroenterology Patient Enrollment Form

UPDATE 10.25

Remicade® INFLIXIMAB | Infliximab | Simponi® golimumab

**Complete and fax this Form to 855-224-5072. All fields are required unless marked optional. Please see Consents and Certifications on page 3 for full details.**
**For assistance, prescribers can call 877-227-3728, Monday–Friday, 8:00 AM–8:00 PM ET.** A completed Patient Authorization Form, found on page 2 of this document, is necessary to access certain patient support under J&J withMe (the "Program"). Please have your patient or the patient's legally authorized representative sign the Patient Authorization Form and submit with this completed Patient Enrollment Form.

▼ TO BE COMPLETED BY PATIENT AND PROVIDER ▼

## 1. Patient Contact Information

FIRST NAME _____ LAST NAME _____ DATE OF BIRTH ____/____/____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____ SEX ☐ MALE ☐ FEMALE

PHONE (one required): HOME _____ MOBILE _____ EMAIL (optional) _____

## 2. Patient Consents

**CONSENT TO PROCESS MY SENSITIVE PERSONAL INFORMATION:** Through my submission of this J&J withMe Patient Enrollment Form, I consent to the collection, use, and disclosure of my sensitive personal information, including health data, for the purposes described in this form and as described in Johnson & Johnson's **Privacy Policy**. My consent is required to process sensitive personal information under certain privacy laws, and I have the right to withdraw my consent at any time by visiting "Privacy Request Form," accessible via the Privacy Policy.

☐ **TEXT MESSAGE CONSENT (OPTIONAL):** I consent to receive automated and recurring text messages about the Program from Johnson & Johnson as set forth on page 2 to the mobile number provided above. Message and data rates may apply. Message frequency varies. I understand that I am not required to consent as a condition of participating in J&J withMe, purchasing any goods or services, or receiving any other communications I have selected. I can reply HELP for help. I can reply STOP to opt out at any time.

☐ **MARKETING CONSENT (OPTIONAL):** I consent to receive communications via mail, email, and telephone from Johnson & Johnson regarding its products, programs, services, scientific research and other research opportunities, and for online targeted advertising, as further described in Johnson & Johnson's **Privacy Policy**.

Please see Consents and Certifications on page 3 for full details.

## 3. Insurance Information

**Provide a copy of the front and back of insurance card(s). (If providing copy of insurance card(s), skip to section 4. Clinical Information.)** ☐ **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 #:** _____

**Medical Insurance** _____ POLICY # _____ GROUP # _____

**Pharmacy Insurance** _____ PCN # _____ GrpRX # _____

POLICY # _____ CARD/BIN # _____

▼ TO BE COMPLETED BY PROVIDER ▼

## 4. Clinical Information

**DIAGNOSIS:** SELECT ONE: ☐ K51.90 Ulcerative Colitis, Unspecified ☐ K50.90 Crohn's Disease, Unspecified ☐ Other ICD-10 Code _____

PATIENT WEIGHT (Required for patients under age 18) _____ kg

PRIOR MEDICINES (optional) _____

## 5. Prescriber Information

PRESCRIBER NAME (First, Last) _____

OFFICE CONTACT (optional) _____ PTAN (Medicare patients only) _____

PRACTICE NAME _____ NPI # _____ TAX ID # (optional) _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

EMAIL _____ PHONE _____ FAX _____

## 6. Prescription Information (Required to complete benefits investigation)

☐ **REMICADE®** or ☐ **Infliximab** **DIAGNOSIS: Crohn's Disease, Fistula (Secondary to Crohn's Disease), Ulcerative Colitis** DIAGNOSIS CODE _____

**STARTER DOSE:** ☐ Infuse ____ mg IV at weeks 0, 2, 6 Vials # (for 1 infusion) ____ Refills # 2 **MAINTENANCE THERAPY:** ☐ Infuse ____ mg IV every ____ weeks thereafter Vials # (for 1 infusion) ____ Refills # ____

☐ **SIMPONI® DIAGNOSIS: Ulcerative Colitis** DIAGNOSIS CODE _____

**For starter dosages, please select both a Week 0 and Week 2 dosage.**

**STARTER DOSE (Week 0):**

- ☐ **40 kg and greater** 200 mg; 2 single-dose prefilled SmartJect® autoinjectors, 100 mg/mL SC
- ☐ **40 kg and greater** 200 mg; 2 single-dose prefilled syringes, 100 mg/mL SC
- ☐ **At least 15 kg to less than 40 kg** 100 mg; 1 single-dose prefilled syringe, 100 mg/mL SC
- ☐ **At least 15 kg to less than 40 kg** 100 mg; 1 single-dose prefilled SmartJect® autoinjector, 100 mg/mL SC

**STARTER DOSE (Week 2):**

- ☐ **40 kg and greater** 100 mg; 1 single-dose prefilled SmartJect® autoinjector, 100 mg/mL SC
- ☐ **40 kg and greater** 100 mg; 1 single-dose prefilled syringe, 100 mg/mL SC
- ☐ **At least 15 kg to less than 40 kg** 50 mg; 1 single-dose prefilled syringe, 50 mg/0.5 mL SC
- ☐ **At least 15 kg to less than 40 kg** 50 mg; 1 single-dose prefilled SmartJect® autoinjector, 50 mg/0.5 mL SC

**MAINTENANCE THERAPY (Week 6 and every 4 weeks thereafter):**

- ☐ **40 kg and greater** 100 mg; single-dose prefilled SmartJect® autoinjector, 100 mg/mL SC Refills #_____
- ☐ **40 kg and greater** 100 mg; single-dose prefilled syringe, 100 mg/mL SC Refills #_____
- ☐ **At least 15 kg to less than 40 kg** 50 mg; single-dose prefilled syringe, 50 mg/0.5 mL SC Refills #_____
- ☐ **At least 15 kg to less than 40 kg** 50 mg; single-dose prefilled SmartJect® autoinjector, 50 mg/0.5 mL SC Refills #_____
- ☐ OTHER _____ Refills #_____

**Ship to Induction or Infusion Site: (ONLY REQUIRED IF DIFFERENT FROM PRESCRIBER'S OFFICE. Shipments cannot be sent to PO boxes.)**

☐ Nonprescriber's Office ☐ Hospital Outpatient ☐ Infusion Center ☐ Other

PHYSICIAN OR INFUSION PROVIDER NAME _____ OFFICE CONTACT NAME _____

PRACTICE/FACILITY NAME _____ NPI # _____ TAX ID # _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

PHONE _____ FAX _____

**PRESCRIBER SIGNATURE(S) (NO STAMPS ALLOWED) REQUIRED TO VALIDATE PRESCRIPTION: I certify that therapy with REMICADE®, Infliximab, or SIMPONI® is medically necessary for this patient. I will be supervising the patient's treatment accordingly, and I have reviewed the current REMICADE®, Infliximab, or SIMPONI® Prescribing Information. By signing below, I authorize the Pharmacy, its affiliates, agents, and contractors to act on my behalf for the limited purposes of transmitting this prescription, by any means allowed under applicable law, to the appropriate pharmacy.**

**J&J Support Program Prescription**

By submitting this prescription, I understand the Program 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 descriptions, program links, and Prescriber Certifications on page 3.

**PRESCRIBER SIGNATURE** (Dispense as written) _____ DATE _____

**Commercial Pharmacy Prescription (Optional): If signed the prescription will triage to the insurance-mandated specialty pharmacy. Do NOT sign if triage is not requested.**

Patient- or Provider-Preferred Pharmacy Information (Please complete if insurance-mandated pharmacy is not required) _____

**PRESCRIBER SIGNATURE** (Dispense as written) _____ DATE _____

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

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# PATIENT AUTHORIZATION FORM ("AUTHORIZATION")

By signing below, I give permission for each of my "Healthcare Providers" (eg, my physicians, pharmacists, specialty pharmacies, other healthcare providers, and their staff) and "Insurers" (eg, my health insurance plans) to share my Protected Health Information ("PHI") as described under J&J's support programs. My PHI includes any and all information related to my medical condition, treatment, prescriptions, health insurance coverage, and other information contained in the Patient Enrollment Form.

I agree that the following entities are permitted to receive, use, and share my PHI:

- Johnson & Johnson Health Care Systems Inc., its affiliated companies, including Patient Service Center LLC, agents, and representatives (collectively "J&J"); and
- Providers of other sources of funding (including foundations and co-pay assistance providers), service providers for J&J's support programs (including subcontractors or healthcare providers helping J&J run the program), and service providers maintaining, transmitting, de-identifying, aggregating, or analyzing data from J&J's support programs (collectively, "Service Providers");
- Pharmacies involved in my care; and Insurers

Also, I give permission to J&J, the Service Providers, my Healthcare Providers, and my Insurers to receive, use, and share my PHI in order to:

- see if I qualify for, sign me up for, contact me about, and provide services relating to J&J's patient support programs, including in-home services
- communicate with my Healthcare Providers regarding access to, reimbursement for, and fulfillment of my J&J medicine, and to tell my Healthcare Provider that I am participating in a support program from J&J
- verify, assist with, and coordinate my coverage for my J&J medicine with my Insurers and Healthcare Providers
- coordinate prescription or treatment location and associated scheduling
- conduct analysis to help J&J evaluate, create, and improve its products, services, and customer support for patients prescribed J&J medicines
- share and give access to information created by J&J's patient support programs that may be useful for my care
- communicate with me by telephone, text message, or email regarding J&J's support programs or other J&J medicines, products, or services for the purposes set forth in the Patient Enrollment Form

I understand that J&J and the Service Providers will use reasonable efforts to keep my information private but once my PHI is disclosed as allowed on this Authorization, it may no longer be protected by federal privacy laws. I understand that I am not required to sign this Authorization. My choice about whether to sign will not change how my Healthcare Providers or Insurers treat me. If I do not sign this Authorization, or cancel or remove my permission later, I understand I will not be able to participate in or receive assistance from certain J&J support programs. I understand that pharmacies that dispense and ship my medicine and service providers for J&J's support programs may be paid by J&J for their services and data. This may include payment for sharing PHI and other data in connection with this program, as allowed on this Authorization.

I understand I may request a copy of this Authorization. This Authorization will remain in effect 10 years from the date of signature, except where state law requires a shorter time, or until I am no longer participating in J&J's support programs. Information collected before that date may continue to be used for the purposes set forth in this Authorization. I understand that I may cancel the permissions given by this Authorization at any time by letting J&J know in writing at: Johnson & Johnson, 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. I further understand that if I cancel my permission it will not affect how J&J uses and shares my PHI received by J&J prior to my cancellation.

My signature below certifies that I have read, understood, and agreed to the release of my protected health information pursuant to this Authorization.

**REQUIRED – SIGNATURE OF PATIENT OR PATIENT'S LEGALLY AUTHORIZED REPRESENTATIVE*:**

_____ Date: _____ /_____ /_____

Print Patient Name: _____ Email Address: _____

Print Legally Authorized Representative Name (if applicable): _____

Relationship to Patient (if applicable): _____

*Only individuals with legal authority to make medical decisions for the patient may sign.

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Johnson&Johnson

## Please provide this Consents and Certifications page to your patient or the caregiver of your pediatric patient

### Patient Consents and Certifications

**Enrolling in J&J withMe.** I am enrolling in J&J withMe, and I authorize Johnson & Johnson Health Care Systems Inc., its affiliated companies, including Patient Service Center LLC, and its vendors, agents, and representatives (collectively, "Johnson & Johnson") to provide me support under the Program. Such support may include:

(i) **Access and Affordability Support:** The Program will help you understand your insurance coverage, cost support options, and support offerings like the J&J withMe Savings Program. To learn more, visit **Remicade.JNJwithMeSavings.com** and **Simponi.JNJwithMeSavings.com**.

(ii) **J&J withMe Delay and Denial Support:** Offers eligible patients SIMPONI® (golimumab) at no cost until their commercial insurance covers the medicine. See program requirements at **SimponiDelayandDenial.com**.

**Verification of Eligibility.** If applicable, I authorize Johnson & Johnson to verify my eligibility for the Program, and I understand that such verification may include contacting me or my healthcare provider for additional information and/or reviewing additional insurance, medical information, and/or financial information. I understand that eligibility for participation in support offerings will be verified periodically.

**Conditions of Participation.** If I receive medicine at no cost from the J&J withMe Delay and Denial Support or participate in the J&J withMe Savings Program, I certify that I will not submit any costs paid by the Program as a claim for payment to any health plan, foundation, flexible spending account, or healthcare savings account. I agree to notify the Program if my insurance changes. Additionally, I understand that the Program may be changed or discontinued without notice.

**Use of Personal Information.** I understand that my personal health data or the patient's (if pediatric patient), contact information, and other identifying information shared by me, my/the patient's healthcare provider, or others with Johnson & Johnson is collected to administer the Program, as explained in Johnson & Johnson's **Privacy Policy** and, if applicable, its affiliated, noncommercial dispensing pharmacy, Access Therapy Center ("Pharmacy"), in accordance with its **Notice of Privacy Practices**.

I understand my consent is needed for processing sensitive personal data under certain privacy laws, and I can withdraw my consent anytime by completing the Privacy Request Form found in the Privacy Policy.

Depending on where I live, I may have rights regarding my information privacy, including requesting access to or deletion of my/the patient's personal information. California residents have specific privacy rights detailed in Johnson & Johnson's California privacy notice.

I understand Johnson & Johnson might not be required to fulfill my requests in certain situations. To exercise these rights, I can contact Johnson & Johnson at 1-800-526-7736 or complete the Privacy Request Form in the Privacy Policy.

**Communications.** I authorize Johnson & Johnson to communicate with me by mail, email, telephone (including cell phone) and, if I indicate my agreement and consent in Section 2 on page 1, by text message (automated and recurring) at the address, email address, phone number, and mobile telephone number(s) provided in Section 1 on page 1. I agree to notify Johnson & Johnson promptly if any of my contact information changes in the future. I understand and acknowledge that communications via mail, email, and telephone may include information about the Program, including refill reminders and Rx notifications and, if I indicate my agreement and consent in Section 2 on page 1, information about REMICADE®, Infliximab, or SIMPONI® disease state and products, promotions, services, research studies, educational and adherence materials, and to seek my opinion about such information and topics, including market research and disease-related surveys. I understand and acknowledge that communications via text message may include information about the Program, including refill reminders and Rx notifications. I understand that I may opt out of receiving future communications at any time by notifying Johnson & Johnson or by following the instructions provided. I understand that if I opt in to receive text messages, the frequency of these messages may vary. I understand that I may opt out of receiving future text messages at any time by replying "STOP," and that I can get help for text messages at any time by replying "HELP" for assistance. Message and data rates may apply. For terms and conditions, please **click here**. I understand and acknowledge that personal information, including the patient's health information, may be used or disclosed as part of the communications, including in any voicemails. Communications transmitted via unencrypted email or text message over an open network may be inherently unsecured, and there is no assurance of confidentiality for information communicated in this manner. Further, emails and text messages have inherent privacy risks, especially when access to computers or mobile devices is not password protected. Nevertheless, I want Johnson & Johnson to communicate with me via email and/or text message as detailed herein. Lastly, I understand that my consent to receive the communications is not required as a condition of participating in the Program, purchasing any goods or services, or receiving any other selected communications from Johnson & Johnson.

### Prescriber Certifications

By submitting the Patient Enrollment Form, I certify that: The person named on the form is my patient; the information provided therein is, to the best of my knowledge, current, complete, and accurate; REMICADE®, Infliximab, or SIMPONI® is medically necessary for this patient; I have prescribed REMICADE®, Infliximab, or SIMPONI® to the patient as indicated on page 1; the decision to prescribe REMICADE®, Infliximab, or SIMPONI® was based solely on my independent medical judgment; and I am authorized under state law to prescribe REMICADE®, Infliximab, and SIMPONI®, have reviewed and signed the prescription, and have otherwise lawfully complied with prescribing requirements under applicable laws and regulations. I will be supervising the patient's treatment, and I have reviewed the current REMICADE®, Infliximab, or SIMPONI® prescribing information, as applicable. Further, I certify that I have reviewed this form with my patient, and that the patient would like to be screened for eligibility for J&J withMe (the "Program") support offerings and the Johnson & Johnson Patient Assistance Program, and enrolled, as applicable, in such support if eligible.

I understand that my patient's information provided to Johnson & Johnson is for the use of the Program solely to verify my patient's insurance coverage; to facilitate the filling of my patient's prescription; to assess my patient's eligibility for the Program offerings and other support programs; and to otherwise administer the Program for the patient. I certify that I am disclosing the patient's protected health information ("PHI") on this form to the Program for treatment, payment, or healthcare operations purposes, in accordance with the requirements under the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, as amended ("HIPAA"). Additionally, I certify that I have obtained the patient's written consent or authorization in accordance with applicable state and federal law, including HIPAA, to provide the PHI on this form to the Program for the purposes set forth here.

I authorize the Program to conduct a benefits investigation for my patient and to act on my behalf for the limited purpose of transmitting this prescription to the appropriate pharmacy based on the results of that benefits investigation. If coverage is available, the Program is authorized to transmit this prescription to a commercial pharmacy based on the patient's health plan requirements unless patient expresses a preference for a different pharmacy. If coverage is not available and the patient qualifies for and enrolls in either J&J withMe Delay and Denial Support or the Johnson & Johnson Patient Assistance Program to receive product at no cost, the Program is authorized to transmit this prescription to a pharmacy that dispenses product at no cost under those programs. I also understand that no request for reimbursement for product at no cost may be submitted to any payer, including Medicare and Medicaid, and that no product at no cost may be sold, traded, or distributed for sale. I consent to Johnson & Johnson contacting me by fax, mail, or email to provide additional information about REMICADE®, Infliximab, and SIMPONI® or the Program. I understand that the Program may revise, change, or terminate any program offerings or resources at any time without notice to me.

### Johnson & Johnson Patient Assistance Program

Patient assistance is available if you are uninsured, or have commercial, employer-sponsored, or government coverage that does not fully meet your needs. You may be eligible to receive your medicine from J&J at no cost for up to one year if you meet the eligibility and income requirements for the Johnson & Johnson Patient Assistance Program.

To learn more about income requirements, terms & conditions, and how to enroll in the Johnson & Johnson Patient Assistance Program, please visit **PatientAssistanceInfo.com/IMM**, or call 844-494-8463.

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

 