Tremfya withMe

Tremfya® (guselkumab)

Rebate Form

Submit this form if your pharmacy can't process your TREMFYA withMe Savings Program Virtual Payment Card.

STEP 1 If you or the patient are not opted in to receive text messages, **you can enroll to receive text message updates. Text "INFO" to 94932**. Message and data rates may apply.*

STEP 2 Use the Virtual Payment Card to complete the information below. Sign the form.

STEP 3 Include a copy of the pharmacy receipt. A valid receipt will include the patient's name, medicine name, date, and amount paid for TREMFYA®. If the receipt includes a prescription number but does not include the medicine name, also include a copy of the prescription label from the medicine carton.

STEP 4 Submit this signed form along with the pharmacy receipt and prescription label from the medicine carton, if required, to the link below. Eligible patients will receive a rebate check in about three weeks. Rebate requests must be submitted within 365 days of the date of service.

*See **Terms** and **Privacy Policy**.

Patient Information (Required)

The information you provide will only be used by Johnson & Johnson Health Care Systems Inc., our affiliates, and our service providers to provide benefits to the patient related to participation in the TREMFYA withMe Savings Program. If you want to stop receiving this information or service, you may withdraw from the program by calling 866-708-8987. Our **Privacy Policy** governs the use of the information you provide.

☐ By providing consent, you agree to the collection and use of your/the patient's Sensitive Personal Information (SPI). Examples of SPI may include, but are not limited to, health-related information. We use this information consistent with our Privacy Policy, including to personalize the information you receive, fulfill any requests you submit, and to research, develop, and improve our products and services. By checking the box, you indicate that you read, understand, and agree to such collection and use of your/the patient's SPI.

Patient Name | Date of Birth (mm/dd/yyyy) | Sex ☐ Male ☐ Female

Address | City | State | ZIP

E-mail | Phone | 11-digit Savings Program ID #

This program is only for people who are prescribed TREMFYA® for an FDA-approved indication, using commercial or private health insurance who must pay an out-of-pocket cost for their TREMFYA® medicine, eligible laboratory tests, and/or TREMFYA® infusion administration. This includes plans from the Health Insurance Marketplace. This program is not for people who use any state or federal government-funded healthcare program. Examples of these programs are Medicare, Medicaid, TRICARE, Department of Defense, and Veterans Administration. You may not seek payment for the value received from this program from any health plan, patient assistance foundation, flexible spending account, or healthcare savings account.

You/the patient must meet the program requirements every time you use the Savings Program. Program terms will expire at the end of each calendar year. The program may change or end without notice, including in specific states. Treatment Administration Cost Support is not valid for residents of MA, MN, or RI. Program participants are subject to an annual maximum benefit. Program benefits are set at the discretion of J&J and may change without notice.

To use this program, you must follow any health plan requirements, including telling your health plan how much co-payment support you get/the patient gets from this program, if required. By using the Savings Program, you confirm that you have read, understood, and agree to the program requirements, and you are giving permission for information related to your Savings Program transactions to be shared with your/the patient's healthcare provider(s). These transactions include rebates and any funds placed on the card or balance remaining on the card. Offer good only in the United States and its territories, excluding states noted above. Void where prohibited, taxed, or limited by law. REBATE FORM CANNOT BE BOUGHT, TRANSFERRED, OR SOLD. REBATE FORM CANNOT BE COMBINED WITH ANY OTHER OFFER, DISCOUNT, PRESCRIPTION SAVINGS CARD, OR FREE TRIAL. Use of this program is subject to the program requirements, which can be found at **TREMFYAwithMeSavings.com**.

By signing, dating, and submitting this form, you confirm that the patient:

- **has enrolled in the TREMFYA withMe Savings Program and downloaded the Virtual Payment Card; and**
- meets the program requirements of the Savings Program, which may also be found at **TREMFYAwithMeSavings.com**.

Patient Signature (If the patient cannot sign, patient's legally authorized representative must sign below) | Patient Name (Please print) | Date

Legally Authorized Representative Signature | Representative Name (Please print) | Date

Questions? Call 866-708-8987, Monday–Friday, 8:00 AM–8:00 PM ET

Online Account: Account.JNJwithMe.com

Online: Account.JNJwithMe.com/submit-rebate

Please read the full Prescribing Information and Medication Guide for TREMFYA®, and discuss any questions you have with your doctor.

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Clear Form Print Form