Tremfya withMe

Tremfya® (guselkumab)

A healthcare provider's guide to

Helping patients manage their Savings Program benefits

You can submit a claim to the TREMFYA withMe Savings Program on behalf of your patients, or your patients can submit a claim on their own.

If you are submitting a claim on behalf of your patient, you will need to submit:



A copy of their Explanation of Benefits (**EOB**) indicating patient responsibility for their TREMFYA® treatment costs. This is required for your patient to receive payment via Virtual Payment Card.

- By submitting an EOB on behalf of a patient, the healthcare provider certifies that they have been authorized by the patient to receive payment directly for the appropriate value of the medical claim submission

Submitting a claim for payment to you by electronic funds transfer (EFT) or check

- For submission, you will need the patient's:
  - TREMFYA withMe Savings Program Medical Claims Member ID
  - Group #
  - Payer ID #56155 (Only needed when using EHR/billing system. Contact your clearinghouse to request that it be added to your system, if needed.)

1 Via EHR or your billing system

- Electronic submission of **secondary claim** to the TREMFYA withMe Savings Program

2 Via portals or fax/mail

- Submit **secondary claim** to the TREMFYA withMe Savings Program using CMS-1500 or UB-04 medical claim forms
- You need to submit the primary EOB along with secondary claim

You will receive funds for approved claims by EFT or check. The check will include information on setting up future payments via EFT, if preferred.

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

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Sample CMS-1500 Claim Form

for Billing in the Physician Office

1 Insured's ID Number

Enter the TREMFYA withMe Savings Program Member Number Medical Claims Member ID

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 TREMFYA®.

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

*CPT® = Current Procedural Terminology. CPT® is a registered trademark of the American Medical Association, 2023.

HCPCS = Healthcare Common Procedure Coding System;
NDC = National Drug Code.

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 (ID#)

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 MM DD YY: 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): TREMFYA® (guselkumab)

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. K51.50 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		N457894065002 ML20 J1628	JA JZ	A		200		NPI	123 456 7890
2	04	01	24	04	01	24	11		96365		A		1		NPI	123 456 7890
3															NPI	
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

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

Tremfya withMe

Tremfya® (guselkumab)

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"

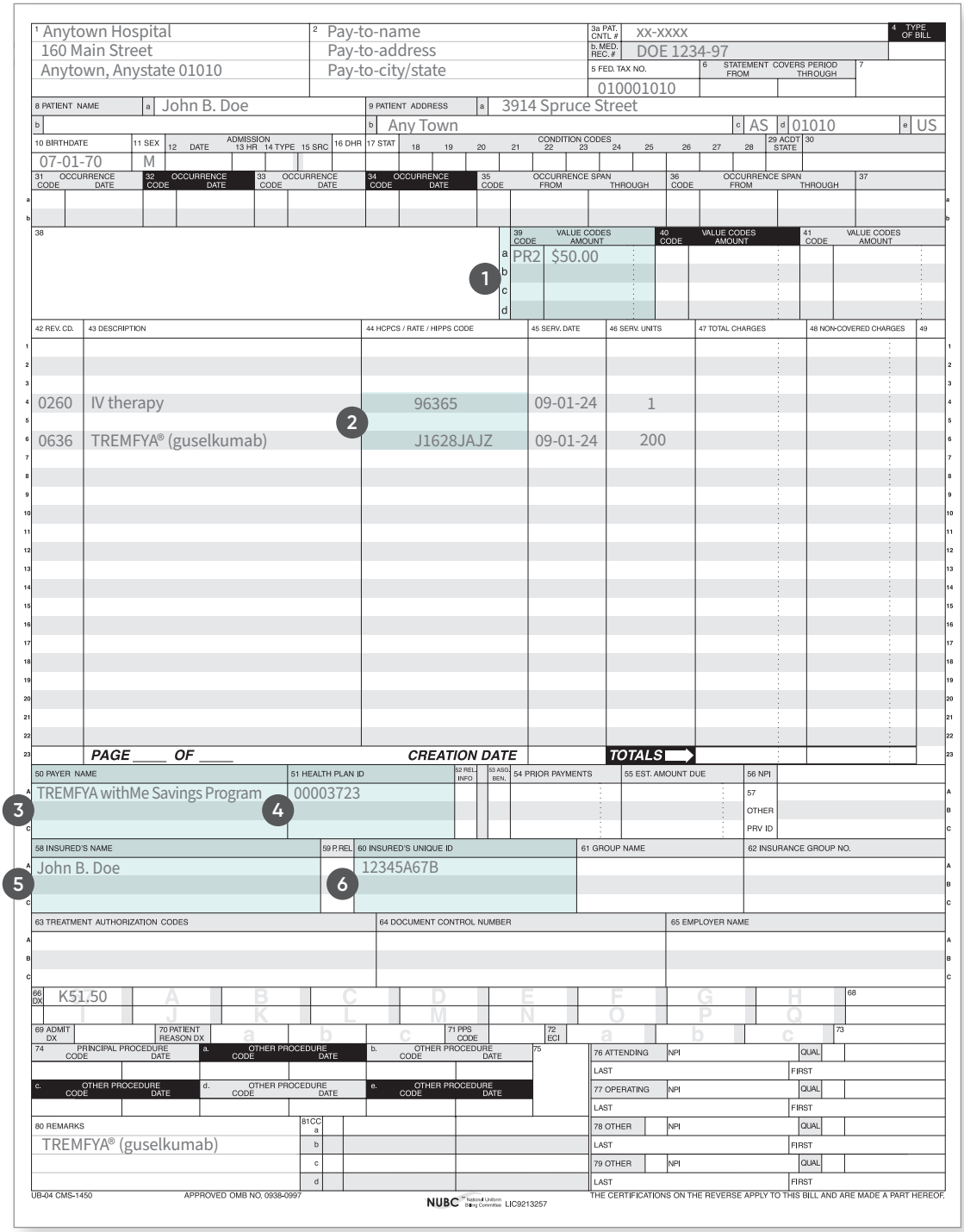
2 HCPCS/Rate/ HIPPS Code
Enter the appropriate J code, S code, or G code

3 Payer Name
Enter "TREMFYA withMe Savings Program"

4 Health Plan ID
Enter the Medical Claims Group #

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

6 Insured's Unique ID
Enter the TREMFYA withMe Savings Program Member Number



1 Anytown Hospital
160 Main Street
Anytown, Anystate 01010

2 Pay-to-name
Pay-to-address
Pay-to-city/state

3a PAT. CNTL # XX-XXXX
b. MED. REC. # DOE 1234-97
4 TYPE OF BILL
5 FED. TAX NO. 010001010
6 STATEMENT COVERS PERIOD FROM THROUGH
7

8 PATIENT NAME a John B. Doe
9 PATIENT ADDRESS a 3914 Spruce Street
b Any Town c AS d 01010 e US

10 BIRTHDATE 07-01-70
11 SEX M
12 DATE 13 HR 14 TYPE 15 SRC 16 DHR 17 STAT
ADMISSION
CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28
29 ACDT STATE
30

31 OCCURRENCE CODE DATE
32 OCCURRENCE CODE DATE
33 OCCURRENCE CODE DATE
34 OCCURRENCE CODE DATE
35 OCCURRENCE SPAN CODE FROM THROUGH
36 OCCURRENCE SPAN CODE FROM THROUGH
37

38

39 VALUE CODES CODE AMOUNT
40 VALUE CODES CODE AMOUNT
41 VALUE CODES CODE AMOUNT
a PR2 $50.00
b
c
d

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0260	IV therapy	96365	09-01-24	1			
0636	TREMFYA® (guselkumab)	J1628JAJZ	09-01-24	200			

PAGE ____ OF ____ CREATION DATE TOTALS

50 PAYER NAME TREMFYA withMe Savings Program
51 HEALTH PLAN ID 00003723
52 REL. INFO
53 ASG. BEN.
54 PRIOR PAYMENTS
55 EST. AMOUNT DUE
56 NPI
57 OTHER PRV ID

58 INSURED'S NAME John B. Doe
59 P. REL
60 INSURED'S UNIQUE ID 12345A67B
61 GROUP NAME
62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME

66 DX K51.50
68

69 ADMIT DX
70 PATIENT REASON DX
71 PPS CODE
72 ECI
73

74 PRINCIPAL PROCEDURE CODE DATE
a. OTHER PROCEDURE CODE DATE
b. OTHER PROCEDURE CODE DATE
c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE
75

76 ATTENDING NPI QUAL LAST FIRST
77 OPERATING NPI QUAL LAST FIRST
78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST

80 REMARKS TREMFYA® (guselkumab)
81CC a b c d

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC LIC9213257 THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

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 TREMFYA®.

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

If you have questions about payment processing, call us at 844-4withMe (844-494-8463).

HCPCS = Healthcare Common Procedure Coding System; HIPPS = Health Insurance Prospective Payment System.

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

Tremfya withMe

Tremfya® (guselkumab)

Once a decision has been made to prescribe TREMFYA®

TREMFYA withMe is here for your patients

What is TREMFYA withMe? Resources and dedicated support for your patients prescribed TREMFYA® for an on-label use. This includes:



Dedicated Nurse Guide*

A qualified healthcare professional committed to helping your patients navigate their treatment, coverage, supplemental injection training, and costs.

*Patient authorization required. Nurse Guides do not provide medical advice.



In-Office Educational Support†

Field Reimbursement Managers (FRMs) provide in-office educational support on reimbursement, access, and fulfillment, helping patients get started on treatment.

†Patient authorization required.



Specialty Pharmacy Enhanced Services

Specialty pharmacies provide enhanced product fulfillment and patient support services such as enhanced prescription transfers and patient outreach.



Affordability Support

TREMFYA withMe provides ongoing support to help patients start and stay on TREMFYA®.

TREMFYA withMe can:

- Verify insurance coverage
- Provide reimbursement information
- Find financial assistance options for eligible patients
- Provide access program support for commercial patients



Need help?

Call **844-4withMe** (844-494-8463)
Monday–Friday, 8:00 AM–8:00 PM ET
Multilingual phone support available

The patient support and resources provided by TREMFYA withMe are not intended to give medical advice, replace a treatment plan from the patient's healthcare provider, offer services that would normally be performed by the provider's office, or serve as a reason to prescribe TREMFYA®.

Information about your patient's insurance coverage, cost support options, and treatment support is given by service providers for TREMFYA withMe. The information you get does not require you or your patient to use any medicine from Johnson & Johnson. Because the information we give you comes from outside sources, TREMFYA withMe cannot promise the information will be complete.

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

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