Janssen CarePath UPDATE 8.18

Benefits Investigation and Prescription Form

Complete and fax this form to 866-769-3903 or mail to 2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560.
For assistance, call 877-CarePath (877-227-3728), Monday–Friday, 8:00 AM–8:00 PM, ET

Stelara® (ustekinumab)

Janssen CarePath cannot accept any information without an executed Business Associate Agreement or Patient Authorization Form, which can be found at JanssenCarePath.com or as the last page of this document.

1. PATIENT INFORMATION (REQUIRED)

NAME (First, MI, Last) _____ SEX ☐ M ☐ F

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____ DOB (MM/DD/YYYY) _____

PRIMARY PHONE (Best number to call 8:00 AM to 8:00 PM) _____

2. INSURANCE INFORMATION (REQUIRED. Include alpha prefix and suffix with policy and group# when applicable or provide a copy of insurance cards)

PRIMARY INSURANCE _____

CARDHOLDER _____ RELATIONSHIP TO CARDHOLDER _____

EMPLOYER _____ INS. CO. PHONE _____

POLICY# _____ GROUP# _____

SECONDARY INSURANCE _____

CARDHOLDER _____ RELATIONSHIP TO CARDHOLDER _____

EMPLOYER _____ INS. CO. PHONE _____

POLICY# _____ GROUP# _____

PRESCRIPTION DRUG INSURER _____ CARD/BIN# _____ PHONE _____

3. CLINICAL INFORMATION (REQUIRED. Visit JanssenCarePath.com for ICD-10 codes or consult the ICD-10 code book for additional information)

PRIMARY DIAGNOSIS: **PSORIASIS** ☐ L40.00 (Psoriatic vulgaris) ☐ Other ICD-10 Code _____

PSORIATIC ARTHROPATHY ☐ L40.50 (Arthropathic psoriasis, unspecified) ☐ Other ICD-10 Code _____

SECONDARY DIAGNOSIS: ICD-10 CODE _____

TB TEST DATE _____ DATE OF DIAGNOSIS OR YEARS WITH DISEASE _____

PATIENT WEIGHT _____ lb. _____ kg. % BSA AFFECTED _____

4. PRESCRIBER INFORMATION (REQUIRED)

PRESCRIBER NAME (First, Last) _____

SPECIALTY _____

PRACTICE NAME _____ OFFICE CONTACT _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

PHONE _____ FAX _____ TAX ID# _____

MEDICAID/MEDICARE PROVIDER# _____ NPI# _____

Please see full Prescribing Information and Medication Guide for STELARA®. Provide the Medication Guide to your patients and encourage discussion.

5. PRIOR THERAPIES (REQUIRED to complete Prior Authorization Form Assistance)

☐ Corticosteroids ☐ Cyclosporine ☐ Enbrel® ☐ Humira® ☐ Methotrexate
☐ Otezla® ☐ Phototherapy ☐ Soriatane® ☐ None of the above ☐ Other _____

6. PRESCRIPTION INFORMATION (If requesting benefits investigation only, do not complete this section. The prescription is only valid if received by fax. If not faxed, prescription must be submitted on state-specific blank, if applicable for your state)

Rx DIRECTIONS

STARTER DOSES REQUESTED SHIP DATE _____

☐ 2 **45 mg vials; 0.75 mg/kg** SC at Week 0 and 4 for plaque psoriasis patients (ages 12–17) weighing less than 60 kg

☐ 2 single-use prefilled syringes; **45 mg** SC at Week 0 and Week 4

☐ 2 single-use prefilled syringes; **90 mg** SC at Week 0 and Week 4

MAINTENANCE THERAPY REQUESTED SHIP DATE _____

☐ 1 **45 mg vial; 0.75 mg/kg** SC every 12 weeks for plaque psoriasis patients (ages 12–17) weighing less than 60 kg Refills # _____

☐ 1 single-use prefilled syringe; **45 mg** SC every 12 weeks Refills # _____

☐ 1 single-use prefilled syringe; **90 mg** SC every 12 weeks Refills # _____

PRESCRIBER SIGNATURE (NO STAMPS ALLOWED) REQUIRED TO VALIDATE PRESCRIPTION: I certify that therapy with STELARA® is medically necessary for this patient. I will be supervising the patient's treatment accordingly, and I have reviewed the current STELARA® Prescribing Information. I authorize Janssen CarePath to act on my behalf for the limited purposes of transmitting this prescription to the appropriate pharmacy designated by me, the patient, or the patient's plan.

PRESCRIBER SIGNATURE (Dispense as written) _____ DATE _____

SUPERVISING PHYSICIAN SIGNATURE (if applicable) _____ DATE _____

SUPERVISING PHYSICIAN NAME _____

7. BENEFITS INVESTIGATION

I would like to request investigation of benefits only for STELARA® at this time ☐ 45 mg single-use prefilled syringe ☐ 90 mg single-use prefilled syringe

I would like to request investigation of benefits only for STELARA® 45 mg single dose vial ☐ 1 vial ☐ 2 vials

SITE OF CARE

☐ Prescribing MD's Office Buy & Bill ☐ Non-prescribing MD's Office/Infusion Center ☐ Hospital Outpatient ☐ Other

PHYSICIAN OR INFUSION PROVIDER NAME _____

PRACTICE/FACILITY NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

PHONE _____ FAX _____ CONTACT NAME _____

INSURANCE PROVIDER# _____ TAX ID# _____

8. PRIOR AUTHORIZATION (Automatically provided with benefits investigation. You may opt out by checking the box below)

Prior Authorization Form Assistance and Status Monitoring: Janssen CarePath assists your office in providing the requirements of the patient's health plan related to prior authorization for treatment with STELARA®. Assistance includes obtaining the health plan-specific prior authorization form, and providing it based upon the patient-specific information provided on this form. The partially completed prior authorization form will be provided to your office for possible completion and submission in the office's sole discretion. Janssen CarePath also actively monitors the status of prior authorization submission to the patient's plan and provides status updates to your office with respect to this patient's prior authorization for treatment with STELARA®.

I do **NOT** wish to receive Prior Authorization Form Assistance or Status Monitoring. ☑

By providing your information and information about your patient on the front of the Benefits Investigation and Prescription Form, you are requesting the services described on this form. The information you provide will only be used by Janssen Biotech, Inc., our affiliates, and our service providers involved in delivering these services. You may withdraw your request for these services by calling 877-CarePath (877-227-3728). Our Privacy Policy, available at **JanssenCarePath.com/Privacy-Policy**, governs the use of the information you provide. By providing the information and submitting this form, you indicate you read, understand, and agree to these terms.

Patient insurance benefits investigation and other Janssen CarePath program offerings are provided by third-party service providers for Janssen CarePath, under contract with Johnson & Johnson Health Care Systems Inc. on behalf of Janssen Pharmaceuticals, Inc., Janssen Biotech, Inc., and Janssen Products, LP (Janssen). Janssen CarePath is not available to patients participating in the Patient Assistance Program offered by Johnson & Johnson Patient Assistance Foundation. The availability of information and assistance may vary based on the Janssen medication, geography and other program differences. Janssen CarePath assists healthcare providers in the determination of whether treatment could be covered by the applicable third-party payer based on coverage guidelines provided by the payer, and patient information provided by the healthcare provider under appropriate authorization following the provider's exclusive determination of medical necessity. This information and assistance are made available as a convenience to patients, and there is no requirement that patients or HCPs use any Janssen product in exchange for this information or assistance. Janssen assumes no responsibility for and does not guarantee the quality, scope, or availability of the information and assistance provided. The third-party service providers, not Janssen, are responsible for the information and assistance provided under this program. Each HCP and patient is responsible for verifying or confirming any information provided. All claims and other submissions to payers should be in compliance with all applicable requirements.

 8/18 cp-18950v2

Janssen
PHARMACEUTICAL COMPANIES OF
Johnson & Johnson

Janssen CarePath Patient Authorization

- **Patients should read the Patient Authorization and sign electronically or download, print, and sign.**
  - **Completed form may be uploaded to Patient Account or Provider Portal, faxed to Janssen CarePath at 866-769-3903, or mailed to address below.**
- **Patients can access a copy of completed form in their Janssen CarePath Account – My Profile.**

My signature on this Patient Authorization Form confirms that I authorize each of my physicians, pharmacists, including any specialty pharmacy that receives my prescription for a Janssen medication and other healthcare providers (together, "Healthcare Providers") and each of my health insurers (together, "Insurers") to disclose my protected health information, including but not limited to information related to my medical condition and treatment, my health insurance coverage, my name, address, telephone number, insurance plan and/or group numbers (together, "Protected Health Information") to Johnson & Johnson Health Care Systems Inc., its affiliated companies, agents and representatives (together, "Janssen"), including providers of alternate sources of funding for prescription drug costs, and other approved service providers authorized to manage, administer, and/or support Janssen CarePath programs, Janssen CarePath Account for Patients, and Provider Portal for their Healthcare Providers for the purposes described below.

Specifically, I authorize Janssen to receive, use, and disclose my Protected Health Information in order to (i) enroll me in, determine my eligibility for, and contact me about, Janssen medication support programs; (ii) provide me with educational materials, information, and services related to my Janssen medication; (iii) verify, investigate, assist with, and coordinate my coverage for my Janssen medication with my Insurers; (iv) coordinate prescription fulfillment; (v) assist with analyses related to the quality, efficacy, and safety of my Janssen medication, and patient access to and adherence to my Janssen medication; (vi) to share and provide access to, information generated by Janssen CarePath that may be useful for my care, and; (vii) to improve, develop, and evaluate Janssen CarePath, its offerings, and materials. I also understand that pharmacies that ship my medication may be paid to share this information with Janssen CarePath to help provide the offerings requested for me. Furthermore, I understand that my Protected Health Information will not be used or disclosed by Janssen for any other purpose without my prior authorization unless permitted by law or unless information that specifically identifies me is removed. I understand that Janssen will make every effort to keep my information private. Further, I understand that if my information is accidentally shared, federal privacy laws do not require that the person/party receiving it not disclose the information further and that such information provided to a third party may no longer be protected by federal privacy laws.

I understand that I am not required to sign this Patient Authorization Form. My choice about whether to sign will not change the way my Healthcare Providers or Insurers treat me. If I refuse to sign the Patient Authorization Form, or revoke my authorization later, I understand that this means I will not be able to participate or receive assistance from Janssen CarePath.

This authorization will last until I am no longer participating in Janssen CarePath, or accessing my Janssen CarePath Account. I understand that I may cancel or revoke this Authorization at any time by mailing a letter requesting such cancellation to Janssen CarePath, 2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560 or by informing my Healthcare Providers and Insurers in writing that I do not want them to share any information with Janssen. I further understand that cancellation or revocation will not affect Janssen's ability to use and disclose Protected Health Information that it has received prior to its receipt of my cancellation and revocation of participation in the program. My authorization will also end if Janssen CarePath support programs or the Janssen CarePath Account is discontinued. Furthermore, I understand that I have the right to see or copy the Protected Health Information my Healthcare Providers or Insurers have given to Janssen.

Patient name: _____ Date of birth (mm/dd/yyyy): _____

Patient address: _____

City: _____ State: _____ ZIP Code: _____

Patient sign here: _____ Date: _____

If patient cannot sign, patient's legally authorized representative must sign below:

By: _____ Date: _____

(Signature of person legally authorized to sign for patient)

Describe relationship to patient and authority to make medical decisions for patient: _____

Janssen CarePath
2250 Perimeter Park Drive, Suite 300
Morrisville, NC 27560
Fax 866-769-3903