janssen CarePath UPDATE 8.18

Benefits Investigation Form

Complete and fax this form to 866-489-5955. For assistance call 877-CarePath (877-227-3728)
Monday–Friday, 8:00 AM–8:00 PM ET.

Remicade® INFLIXIMAB

Janssen CarePath cannot accept any information without an executed Business Associate Agreement or Patient Authorization Form, which can be found at JanssenCarePath.com.

1. PRESCRIBER INFORMATION (REQUIRED)

Prescriber name _____
Practice name _____
Address _____
City _____ State _____ ZIP _____
Phone _____ Fax _____
Office contact name _____ Ext. _____
Provider specialty _____
Provider # (as it pertains to commercial insurance below) _____
Medicaid/Medicare provider # _____
Tax ID # _____ UPIN/NPI # _____

Are you the prescribing specialist? (REQUIRED)

☐ Yes ☐ No (If No, complete section 1B)

1B. Name of Referring Specialist _____
Referring physician specialty _____

2. PATIENT INFORMATION (REQUIRED)

Name (First, MI, Last) _____
Address _____
City _____ State _____ ZIP _____
Home phone _____
DOB (MM/DD/YYYY) _____ Gender ☐ Male ☐ Female

3. INSURANCE INFORMATION (REQUIRED)

(Fax copy of enlarged patient insurance card(s) or provide the information below)

Insurance company #1 _____
Primary insured name _____
Employer _____
Insurance company phone _____
Policy # _____ Group # _____
(Please include alpha prefix and suffix where applicable)
Insurance company #2 _____
Primary insured name _____
Employer _____
Insurance company phone _____
Policy # _____ Group # _____
(Please include alpha prefix and suffix where applicable)

☐ Is patient a dependent of the insured (child <18 yrs; student >18 yrs)? Check if yes.

☐ **Please investigate out-of-network benefits**

MEDICAL HISTORY (REQUIRED. Visit JanssenCarePath.com for ICD-10 codes or consult the ICD-10 code book for additional information)

Primary Diagnosis:
Diagnosis Code _____ Indication _____

Secondary Diagnosis:
Diagnosis Code _____ Indication _____

Comment/Other _____

Date of diagnosis or years with disease _____

4. THERAPY WITH REMICADE®

Previous TB test (date) _____ Hepatitis B Virus test (date) _____
Dosage/frequency _____
Patient weight _____ lb. _____ kg. # of vials to be used _____
Anticipated # of infusions _____
Number of prior REMICADE® infusions ☐ unknown ☐ 0 ☐ 1-3 ☐ 4+
Scheduled date of infusion _____

5. MEDICATIONS (Specify current dosage and time on therapy)

Therapy	Dosage	P = Prior C = Current F = Failure	Months <3	3–6	>6
☐ 5-ASA			☐	☐	☐
☐ Azulfidine®			☐	☐	☐
☐ Azathioprine			☐	☐	☐
☐ 6-MP			☐	☐	☐
☐ Prednisone			☐	☐	☐
☐ Methotrexate			☐	☐	☐
☐ Cyclosporine			☐	☐	☐
☐ Retinoids			☐	☐	☐
☐ Gold compounds			☐	☐	☐
☐ Hydroxychloroquine			☐	☐	☐
☐ Cyclophosphamide			☐	☐	☐
☐ Penicillamine			☐	☐	☐
☐ Leflunomide			☐	☐	☐
☐ Enbrel®			☐	☐	☐
☐ Kineret®			☐	☐	☐
☐ Humira®			☐	☐	☐
☐ Orencia®			☐	☐	☐
☐ Rituxan®			☐	☐	☐
☐ Phototherapy			☐	☐	☐
☐ Other: _____			☐	☐	☐

6. PRIOR AUTHORIZATION

If you would like Janssen CarePath to provide support for the prior authorization process, please check the appropriate box(es):

☐ **Prior Authorization Form Assistance**

By checking this box, I request that Janssen CarePath assist my office in providing the requirements of this patient's health plan related to prior authorization for treatment with REMICADE®. I understand that assistance includes obtaining the health plan-specific prior authorization form, and providing it based upon the patient-specific information provided on this form. I understand that the partially completed prior authorization form will be provided to my office by Janssen CarePath for possible completion and submission in the office's sole discretion.

☐ **Prior Authorization Status Monitoring**

By checking this box, I request that Janssen CarePath actively monitor the status of the prior authorization submission. I request that Janssen CarePath provide status updates to my office with respect to this patient's prior authorization for treatment with REMICADE®.

7. PREFERRED SITE OF INFUSION (REQUIRED)

☐ Prescribing MD's office ☐ Non-prescribing MD's office ☐ Other
☐ Hospital outpatient ☐ Home infusion/Infusion Provider Company

(Fields below do not need to be completed if information is the same as in section 1)

Physician or infusion provider name _____
Physician specialty _____
Practice/facility name _____
Address _____
City _____ State _____ ZIP _____
Phone _____ Fax _____
Contact name _____
Insurance provider # _____ Tax ID # _____

Please see full Prescribing Information, including Boxed Warnings, and Medication Guide for REMICADE®. Provide the Medication Guide to your patients and encourage discussion.

By providing your information and information about your patient on the front of the Benefits Investigation 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.

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