INSTRUCTIONS FOR ENROLLMENT

Patient Assistance Enrollment Form

Janssen believes that access and affordability challenges shouldn't stand in the way of patients and their medications. That's why we are expanding our patient assistance offerings to better serve insured patients who have inadequate coverage and are not supported by other Janssen offerings. Beginning January 1, 2023, Janssen medications may be provided free of charge to eligible patients who are insured through commercial, employer group, or government insurance plans.

ENROLLMENT CHECKLIST

- ☐ Complete all sections of page 2
- ☐ Review and sign the Patient Authorization on pages 4 & 5
- ☐ Ask your Healthcare Provider to complete and sign page 6 (complete a copy of page 6 for each medication)
- ☐ Gather any required supporting documents* to determine what documents you need to include (if any)

*SUPPORTING DOCUMENTS

- ☐ Insurance Information: copies of the front and back of all insurance card(s) (e.g., medical, pharmacy, etc., if you did not complete section 2 on page 2)
- ☐ Proof of income: a copy of your most recent 1040 or 1040-SR Federal tax return, if you did not check the box in section 3 on page 2
- ☐ Medicare Part D Patients only: Submit a report from your pharmacy **OR** an Explanation of Benefits (EOB) statement from your insurer that shows your out-of-pocket costs for the current year

Fax the completed form and supporting documents to: 1-833-512-0497
For assistance on how to complete the form or questions about the program, call **1-833-742-0791**, Monday through Friday, 8:00 AM to 8:00 PM ET.

Medications Available Through This Form

BALVERSA®* (erdafitinib) Tablets, for oral use
DARZALEX®* (daratumumab) Injection for intravenous infusion
DARZALEX *FASPRO*®* (daratumumab and hyaluronidase-fihj) Injection for subcutaneous use
EDURANT®* (rilpivirine) Tablets
ELMIRON®* (pentosan polysulfate sodium) Capsules
ERLEADA®* (apalutamide) Tablets, for oral use
Infliximab* Intravenous infusion
INTELENCE®* (etravirine) Tablets
INVEGA HAFYERA™† (paliperidone palmitate) Extended-release injectable suspension
INVEGA SUSTENNA®† (paliperidone palmitate) Extended-release injectable suspension
INVEGA TRINZA®† (paliperidone palmitate) Extended-release injectable suspension
INVOKAMET®† (canagliflozin/metformin HCl) Tablets
INVOKAMET® XR† (canagliflozin/metformin HCl) Extended-release tablets
INVOKANA®* (canagliflozin) Tablets
PONVORY®* (ponesimod) Tablets
PREZCOBIX®* (darunavir 800 mg/cobicistat 150 mg) Tablets
PREZISTA®* (darunavir) Tablets or oral suspension
REMICADE®† (infliximab) Intravenous infusion
RISPERDAL CONSTA®† (risperidone) Long-acting injection
RYBREVANT®* (amivantamab-vmjw) Injection, for intravenous use
SIMPONI®* (golimumab) Injection
SIMPONI ARIA®† (golimumab) Intravenous infusion
SIRTURO®† (bedaquiline) Tablets
SPRAVATO®* (esketamine) Nasal Spray CIII, for intranasal use
STELARA®* (ustekinumab) Injection, for intravenous use
STELARA®* (ustekinumab) Injection, for subcutaneous use
SYMTUZA®† (darunavir, cobicistat, emtricitabine, and tenofovir alafenamide) Tablets
TECVAYLI™* (teclistamab) Injection, for subcutaneous use
TREMFYA®* (guselkumab) Prefilled syringe or one-press patient-controlled injector
XARELTO®† (rivaroxaban) Tablets or oral suspension
YONDELIS®* (trabectedin) Injection for intravenous use

*Please see Important Safety Information and full Prescribing Information available at https://www.janssencarepath.com/patient/important-safety-information and available from your Janssen representative.

†Please see Important Safety Information, including Boxed Warning, and full Prescribing Information available at https://www.janssencarepath.com/patient/important-safety-information and available from your Janssen representative.

SUBMIT THIS PAGE

Patient Assessment Enrollment Form

The information you provide will be used by Janssen Pharmaceuticals, Inc., our affiliates and our service providers to determine your eligibility for and enroll you in the program. You may withdraw your request for these services by calling 1-833-742-0791. Our Privacy Policy, located at https://www.newprogramsinfo.com/privacy-policy, further governs the use of the information you provide.

TO BE COMPLETED BY PATIENT: All information is required.

1. Patient Information

First Name: _____ Last Name: _____ Phone: _____

Email: _____ Social Security #: _____ Date of Birth (*mm/dd/yyyy*): _____ Gender: _____

Address Line 1: _____ Address Line 2: _____

City: _____ State: _____ ZIP Code: _____

Employer Name: _____

This is the address that all self-administered medication will be shipped to. For a change of address, please contact 833-742-0791 as well as share the information with your Healthcare Provider.

2. Insurance Information *(Complete for all available insurance OR submit copies of front and back of all insurance cards)*

Primary Prescription Insurance: _____ Card BIN #: _____ Phone: _____

Cardholder Name (*First, MI, Last*): _____ Relationship to Cardholder: _____

Policy #: _____ Group #: _____

Primary Medical Insurance: _____ Phone: _____

Cardholder Name (*First, MI, Last*): _____ Relationship to Cardholder: _____

Policy #: _____ Group #: _____

Secondary Medical Insurance: _____ Phone: _____

Cardholder Name (*First, MI, Last*): _____ Relationship to Cardholder: _____

Policy #: _____ Group #: _____

3. Financial Information

Total Gross Annual Income
Entire household: $ _____

Household Size
Including yourself, the number of people who live in your home and are dependent on your household income: _____

Federal Taxes *(Select one of the options below **ONLY** if you do not check the box at the bottom of this page for Applicant Financial Verification Authorization.)*

☐ A copy of my most recent 1040 or 1040-SR Federal tax return is attached. *(Not required for SIRTURO® applications.)*

☐ I do not file Federal taxes. *(Tax returns may be reviewed and additional documentation requested.)*

CHECK THE BOX:

☐ **Applicant Financial Verification Authorization**
I understand that Johnson & Johnson Health Care Systems Inc. (JJHCS) and the vendors associated with administrating the Program (collectively the "Program Administrators") may obtain a credit report or investigative credit report about me (only needed if you did not complete your 1040), which may contain information as to my income or credit standing, to determine my eligibility for the Program. I hereby authorize such credit report and income verification and acknowledge that such authorization extends to consumer reporting agencies and to subsequent reports for purposes of determining my eligibility for the JJHCS Program.

Patient Assistance Enrollment Form

I understand that JJHCS and third parties associated with administrating the Program on behalf of JJHCS (collectively, the "Program Administrators"):

- Reserve the right without notice to change the application form, change the Program or Program criteria, or to terminate my enrollment at any time;
- May request and obtain information about my or my family's income, including verification of my income, or my insurance coverage, including documentation of any insurance denials, and that the information may be requested from me, others acting on my behalf or third-party sources;
- May request that I re-verify my eligibility to receive medicines under the Program

I certify that:

- All the information on this form and all the documentation submitted are complete and correct, and to the best of my knowledge, I meet the eligibility requirements for the submission of the application
- I am completing this application voluntarily. I have not been directed by my insurance company or by a non-medical professional to complete this application. I have not been offered any financial or other benefit by any third party in order to seek assistance from Johnson & Johnson Patient Healthcare Systems, Inc. (JJHCS) and I have not been told that any benefit will be denied or withheld (such as insurance coverage) if I do not complete this application
- I have completed this application myself or with the assistance of a legally authorized representative (such as a guardian), family member, caregiver, friend, healthcare provider or representative of a patient organization. If such assistance was provided, I have reviewed the application before submission to JJHCS to ensure all information is accurate and true. No other third party has assisted with the completion of this application
- The product(s) provided under this patient assistance program will not be sold or traded
- I will notify the Janssen Support Program within thirty (30) days if there is any change in my income or health insurance coverage. This includes a change in my eligibility to participate in the Medicare program due to changes in my age or disability status or my enrollment in Medicare Part D
- I will not attempt to claim or submit any costs associated with the medicine(s) I receive under the Janssen Support Program to any person or entity, including my Medicare Part D plan
- I will not seek true out-of-pocket (TrOOP) credit under the Medicare Part D program for the cost of the medicine(s) I receive under this program

SIGN & DATE:

Patient Name (*print*): _____

Patient Sign Here: _____ Date (*mm/dd/yyyy*): _____

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

By: _____ Print Name: _____ Date (*mm/dd/yyyy*): _____
(Signature of person legally authorized to sign for patient)

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

_____

Patient Authorization Form

Patients should read the Patient Authorization, check the desired permission boxes, and return both pages of the Form to the Janssen Patient Support Program.

- Download a copy, print, check the desired boxes, and sign. Your Healthcare Provider (HCP) may scan the completed Form and upload on Provider Portal, or completed Form may be faxed to 1-844-286-5444 or mailed to Janssen CarePath, 2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560
- You may be able to eSign a digital Form in your HCP's office or on the Janssen CarePath Patient Account at **MyJanssenCarePath.com**

Patient Name: _____ Date of Birth (*mm/dd/yyyy*): _____

Patient Address: _____

City: _____ State: _____ ZIP Code: _____

Phone Number: _____ Email Address: _____

I give permission for each of my "Healthcare Providers" (eg, my physicians, pharmacists, specialty pharmacies, other HCPs, and their staff) and "Insurers" (eg, my health insurance plans) to share my Protected Health Information as described on this Form.

My "Protected Health Information" includes any and all information related to my medical condition, treatment, prescriptions, and health insurance coverage.

The following person(s) or class of person(s) are given permission to receive and use my Protected Health Information (collectively "Janssen"):

- Johnson & Johnson Health Care Systems Inc., its affiliated companies, agents, and representatives
- Providers of other sources of funding, including foundations and co-pay assistance providers
- Service providers for the patient support programs, including subcontractors or HCPs helping Janssen run the programs
- Service providers maintaining, transmitting, de-identifying, aggregating, or analyzing data from Janssen patient support programs

Also, I give permission to Janssen to receive, use, and share my Protected Health Information in order to:

- See if I qualify for, sign me up for, contact me about, and provide services relating to Janssen patient support programs, including in-home services
- Manage the Janssen patient support programs
- Give me educational and adherence materials, information, and resources related to my Janssen medication in connection with Janssen patient support programs
- Communicate with my HCPs regarding access to, reimbursement for and fulfillment of my Janssen medication, and to tell my HCPs that I am participating in Janssen patient support programs
- Verify, assist with, and coordinate my coverage for my Janssen medication with my Insurers and HCPs
- Coordinate prescription or treatment location and associated scheduling
- Conduct analysis to help Janssen evaluate, create, and improve its products, services, and customer support for patients prescribed Janssen medications
- Share and give access to information created by the Janssen patient support programs that may be useful for my care

I understand that my Protected Health Information may be shared by Janssen for the uses written in this Form to:

- My Insurers
- My HCPs
- Any of the persons given permission to receive and use my Protected Health Information as mentioned above
- Any individual I give permission as an additional contact

Janssen and the other data recipients listed on this Form may share information about me as permitted on this Form or if any information that specifically identifies me is removed. I understand that Janssen will use reasonable efforts to keep my information private, but once my Protected Health Information is disclosed as allowed on this Form, it may no longer be protected by federal privacy laws.

Patient Authorization Form

I understand that I am not required to sign this Form. My choice about whether to sign will not change how my HCPs or Insurers treat me. If I do not sign this Form, or cancel or remove my permission later, I understand I will not be able to participate or receive assistance from Janssen's patient support programs.

I understand that pharmacies that dispense and ship my medication and service providers for the patient support programs may be paid by Janssen for their services and data. This may include payment for sharing Protected Health Information and other data in connection with these programs, as allowed on this Form.

This Form 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 any Janssen patient support programs. Information collected before that date may continue to be used for the purposes set forth in this Form.

I understand that I may cancel the permissions given by this Form at any time by letting Janssen know in writing at: Janssen CarePath, 2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560.

I can also cancel my permission by letting my HCPs and Insurers know in writing that I do not want them to share any information with Janssen.

I further understand that if I cancel my permission it will not affect how Janssen uses and shares my Protected Health Information received by Janssen prior to my cancellation.

I understand I may request a copy of this Form.

Permission for communications outside of Janssen patient support programs:

☐ Yes, I would like to receive communications relating to my Janssen medication.

☐ Yes, I would like to receive communications relating to other Janssen products and services.

For privacy rights and choices specific to California residents, please see Janssen's California privacy notice available at **https://www.janssen.com/us/privacy-policy#california**

Permission for text communications:

☐ Yes, I would like to receive text messages. By selecting this option, I agree to receive text messages as allowed by this Form to the cell phone number provided below. Message and data rates may apply. Message frequency varies. I understand I am not required to provide my permission to receive text messages to participate in the Janssen patient support programs or to receive any other communications I have selected.

Cell Phone Number: _____

SIGN & DATE:

Patient Name (*print*): _____

Patient Sign Here: _____ Date (*mm/dd/yyyy*): _____

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

By: _____ Print Name: _____ Date (*mm/dd/yyyy*): _____
(Signature of person legally authorized to sign for patient)

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

_____

SUBMIT THIS PAGE

Patient Assistance Enrollment Form

The information you provide will be used by Janssen Pharmaceuticals, Inc., our affiliates and our service providers to determine your patient's eligibility for and to enroll your patient in the program. You may withdraw your request for these services by calling 1-833-742-0791. Our Privacy Policy, located at https://www.newprograminfo.com/privacy-policy, further governs the use of the information you provide.

TO BE COMPLETED BY HEALTHCARE PROVIDER: All information is required.

1. Prescription *(Please complete a copy of this page for each medication and dosage strength you are requesting.)*

Patient First Name: _____ Patient Last Name: _____

Date of Birth (*mm/dd/yyyy*): _____ ICD Code: _____

Name of Product: _____ Strength: _____

Sig: _____ Quantity: _____ Day Supply: _____

First Time Fill: ☐ Yes ☐ No Number of Refills (*maximum 11*): _____ Anticipated 2023 First Fill Date: _____

Patient Allergies: _____ or ☐ none

List of Patient's Current Medications: _____ or ☐ none

For SPRAVATO®: Due to the product being a controlled substance, an Rx cannot be captured in the Patient Enrollment Form. An electronic prescription must be sent to "*Wegmans Specialty Pharmacy* #198" directly from the HCP.

2. HCP Information *(The address you provide here will be used to ship infused medications. Self-administered medications will be shipped directly to the Patient.)*

First Name: _____ Last Name: _____ Site Name: _____

Site Contact: _____ Business Hours: _____

Address Line 1: _____ Address Line 2: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____ Email: _____

Tax ID #: _____ NPI #: _____

State License #: _____ Expiration (*mm/yyyy*): _____ DEA #: _____

Collaborating MD (*for mid-level providers*) : _____ Collaborating MD NPI #: _____

Provider Transaction Access Number (PTAN) (*required if the patient has Medicare*): _____

HCP Distribution Shipping Address for SPRAVATO® and TECVAYLI™ REMS-Certified Treatment Center Address (if different from above):

Site Name: _____ Contact Name for Shipment: _____

Business Hours: _____ Phone: _____ Fax: _____

Address Line 1: _____ Address Line 2: _____

City: _____ State: _____ Zip Code: _____

3. HCP Authorization

My signature below indicates that I have read, understand, and agree to the Johnson & Johnson Health Care Systems Inc. policy and the terms of Program participation.

HCP SIGN & DATE:

_____ Date (*mm/dd/yyyy*): _____

Healthcare Provider Signature

Clear Form Print Form

Patient Assistance Enrollment Form

Terms & Conditions

PATIENT ASSISTANCE PROGRAM

You may be eligible to receive your Janssen medication(s) free of charge for up to one year if you have been prescribed a Janssen medication included in the program and currently use government, commercial or employer group insurance for your Janssen medication(s). This includes plans from the Health Insurance Marketplace.

You must meet the eligibility and income requirements for the patient assistance program. The program is based on medication costs only and does not include costs to give you your treatment.

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 are not eligible for free medication if you, your employer, or your health insurance provider participate in any alternative funding program or similar scheme, including without limitation any arrangement which denies, restricts, eliminates, delays, alters or withholds any of your insurance benefits or coverage contingent upon your application to this program or directly or indirectly makes insurance coverage of a drug conditional, in whole or in part, on denial of eligibility for assistance under this or any other patient assistance program or otherwise has the effect of altering your insurance coverage or benefit in order to make you eligible for this or any other patient assistance program or to shift cost onto this or any other patient assistance program.

You must meet the program requirements every time you use the program.

Program terms will expire at the end of each calendar year and may change or end without notice, including in specific states.

Before you enroll in the patient assistance program, it is important you understand that you will be asked to provide personal information that may include your name, address, phone number, email address, financial information, and information related to your prescription medication insurance and treatment. This information will be used by Janssen Pharmaceuticals, Inc., and its service providers to determine your eligibility for, enroll you in, and administer the program. The information will also be used to learn more about the people who use the program, to improve the program, and will be shared with service providers supporting the program.

If you have Medicare Prescription Drug Coverage (Part D) you may be asked to attest to or submit a report from your pharmacy or an Explanation of Benefits (EOB) statement from your insurer that shows your out-of-pocket costs for the current year. In order to qualify for the program, 4% of your gross annual household income must be spent on out-of-pocket prescription expenses for you and/or other members of your household.

This program offer may not be used with any other coupon, discount, prescription savings card, free trial, or other offer. Offer good only in the United States and its territories. Void where prohibited, taxed, or limited by law. You may end your participation in the program at any time by calling 1-833-742-0791, Monday through Friday, 8:00 AM to 8:00 PM ET.