

# Patient Assistance Enrollment Form

Janssen believes that access and affordability challenges shouldn't stand in the way of patients and their medications. Janssen medications may be provided free of charge to eligible patients who have inadequate coverage through commercial, employer group, or government insurance plans and are not supported by other Janssen offerings.

## ENROLLMENT CHECKLIST

- Complete all sections of page 2 and sign page 3
- Review and sign the Patient Authorization on pages 4 & 5 or by going to [JanssenPatientAssistance.com/PA](https://www.janssenpatientassistance.com/PA). If you have already completed a Janssen Patient Support Programs Patient Authorization, you do not need to do it again. Additionally, if your doctor's office has a signed Business Associate Agreement (BAA) with Janssen CarePath, you do not need to complete the Patient Authorization
- 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) (eg, medical, pharmacy, etc, if you did not complete section 2 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

**Complete this Patient Assistance Enrollment Form to the best of your abilities, including the supporting documents and fax to: 833-512-0497.** Any required information you did not provide with your initial submission will cause delays in processing your application. For assistance on how to complete the form or questions about the program, call **833-742-0791**, Monday through Friday, 8:00 AM to 8:00 PM ET.

## Medications Available Through This Form

**AKEEGA**<sup>TM\*</sup> (niraparib/abiraterone acetate) Tablets, for oral use  
**BALVERSA**<sup>®\*</sup> (erdafitinib) Tablets, for oral use  
**DARZALEX**<sup>®\*</sup> (daratumumab) Injection for intravenous infusion  
**DARZALEX FASPRO**<sup>®\*</sup> (daratumumab and hyaluronidase-fihj) Injection for subcutaneous use  
**EDURANT**<sup>®\*</sup> (rilpivirine) Tablets  
**ELMIRON**<sup>®\*</sup> (pentosan polysulfate sodium) Capsules  
**ERLEADA**<sup>®\*</sup> (apalutamide) Tablets, for oral use  
**Infliximab**<sup>†</sup> Intravenous infusion  
**INTELENCE**<sup>®\*</sup> (etravirine) Tablets  
**INVEGA HAFYERA**<sup>®†</sup> (paliperidone palmitate) Extended-release injectable suspension  
**INVEGA SUSTENNA**<sup>®†</sup> (paliperidone palmitate) Extended-release injectable suspension  
**INVEGA TRINZA**<sup>®†</sup> (paliperidone palmitate) Extended-release injectable suspension  
**INVOKAMET**<sup>®†</sup> (canagliflozin/metformin HCl) Tablets  
**INVOKAMET<sup>®</sup> XR<sup>†</sup>** (canagliflozin/metformin HCl) Extended-release tablets  
**INVOKANA**<sup>®\*</sup> (canagliflozin) Tablets

**PONVORY**<sup>®\*</sup> (ponesimod) Tablets  
**PREZCOBIX**<sup>®\*</sup> (darunavir 800 mg/cobicistat 150 mg) Tablets  
**PREZISTA**<sup>®\*</sup> (darunavir) Tablets or oral suspension  
**REMICADE**<sup>®†</sup> (infliximab) Intravenous infusion  
**RISPERDAL CONSTA**<sup>®†</sup> (risperidone) Long-acting injection  
**RYBREVANT**<sup>®\*</sup> (amivantamab-vmjw) Injection, for intravenous use  
**SIMPONI**<sup>®†</sup> (golimumab) Injection  
**SIMPONI ARIA**<sup>®†</sup> (golimumab) Intravenous infusion  
**SPRAVATO**<sup>®†</sup> (esketamine) Nasal Spray CIII, for intranasal use  
**STELARA**<sup>®\*</sup> (ustekinumab) Injection, for intravenous use  
**STELARA**<sup>®\*</sup> (ustekinumab) Injection, for subcutaneous use  
**SYMTUZA**<sup>®†</sup> (darunavir, cobicistat, emtricitabine, and tenofovir alafenamide) Tablets  
**TALVEY**<sup>TM†</sup> (talquetamab-tgvs) Injection, for subcutaneous use  
**TECVAYLI**<sup>®†</sup> (teclistamab-cqyv) Injection, for subcutaneous use  
**TREMFYA**<sup>®\*</sup> (guselkumab) Prefilled syringe or one-press patient-controlled injector  
**XARELTO**<sup>®†</sup> (rivaroxaban) Tablets or oral suspension  
**YONDELIS**<sup>®\*</sup> (trabectedin) Injection for intravenous use

\*Please see Important Safety Information and full Prescribing Information available at [janssen-carepath.com/patient/important-safety-information](https://www.janssen-carepath.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 [janssen-carepath.com/patient/important-safety-information](https://www.janssen-carepath.com/patient/important-safety-information) and available from your Janssen representative.

# Patient Assistance 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 833-742-0791. Our [Privacy Policy](#) further governs the use of the information you provide. By submitting this form, you indicate that you read, understand, and agree to these terms.

## TO BE COMPLETED BY PATIENT

Fields marked with a (\*) are required

### 1. Patient Information

\*First Name: \_\_\_\_\_ \*Last Name: \_\_\_\_\_ \*Phone: \_\_\_\_\_  
 Email: \_\_\_\_\_ \*Date of Birth (mm/dd/yyyy): \_\_\_\_\_ \*Gender: \_\_\_\_\_  
 \*Address Line 1: \_\_\_\_\_ Address Line 2: \_\_\_\_\_  
 \*City: \_\_\_\_\_ \*State: \_\_\_\_\_ \*ZIP Code: \_\_\_\_\_  
 \*Product Name: \_\_\_\_\_

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

I agree to receive phone calls via an automatic telephone dialing system. I understand that I am not required to provide my permission to receive such phone calls to participate in Janssen patient support programs or to receive any other communications I have selected.

### 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 #: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Primary Medical Insurance:** \_\_\_\_\_ Phone: \_\_\_\_\_  
 Cardholder Name (First, MI, Last): \_\_\_\_\_ Relationship to Cardholder: \_\_\_\_\_  
 Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Secondary Medical Insurance:** \_\_\_\_\_ Phone: \_\_\_\_\_  
 Cardholder Name (First, MI, Last): \_\_\_\_\_ Relationship to Cardholder: \_\_\_\_\_  
 Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

\*Cardholder Employer Name: \_\_\_\_\_ \*Cardholder Employer Phone: \_\_\_\_\_  
 \*Address Line 1: \_\_\_\_\_ Address Line 2: \_\_\_\_\_  
 \*City: \_\_\_\_\_ \*State: \_\_\_\_\_ \*ZIP Code: \_\_\_\_\_  
 Fax: \_\_\_\_\_

### 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: \_\_\_\_\_

(The credit check is required to confirm you meet the income eligibility. This will not impact patient's credit score.)

CHECK  
THE BOX:

#### \*Applicant Financial Verification Authorization

I understand that Johnson & Johnson Health Care Systems Inc. (JJHCS) and the vendors associated with administering the Program (collectively the "Program Administrators") may obtain a credit report or investigative credit report about me, 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 credit reports for purposes of determining my continued 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 fax the completed Form to **833-512-0497**
- You may be able to eSign a digital Form in your HCP's office or at [JanssenPatientAssistance.com/PA](https://JanssenPatientAssistance.com/PA)

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 [janssen.com/us/privacy-policy#california](https://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:  
\_\_\_\_\_

# Patient Assistance Prescription 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 833-742-0791. Our [Privacy Policy](#) further governs the use of the information you provide.

## TO BE COMPLETED BY HEALTHCARE PROVIDER

Fields marked with a (\*) are 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: \_\_\_\_\_ \*Patient Phone: \_\_\_\_\_  
 \*Patient Address Line 1: \_\_\_\_\_ Patient Address Line 2: \_\_\_\_\_  
 \*Patient City: \_\_\_\_\_ \*Patient State: \_\_\_\_\_ \*Patient ZIP Code: \_\_\_\_\_  
 \*Date of Birth (mm/dd/yyyy): \_\_\_\_\_ Patient Weight: \_\_\_\_\_ Patient Height: \_\_\_\_\_ \*Patient Gender: \_\_\_\_\_  
 \*ICD Code: \_\_\_\_\_ \*Name of Product: \_\_\_\_\_ \*Strength: \_\_\_\_\_  
 \*Sig: \_\_\_\_\_ \*Quantity: \_\_\_\_\_ Day Supply: \_\_\_\_\_  
 First Time Fill:  Yes  No \*Number of Refills (maximum 11): \_\_\_\_\_ \*Need by Date: \_\_\_\_\_

\*Ship to Location:  Patient Home (same as above)  Prescriber Office (same as section 2. HCP Information)  Treatment Center (if different from Prescriber Office)

Site Name: \_\_\_\_\_ Contact Name for Shipment: \_\_\_\_\_  
 Business Hours: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Address Line 1: \_\_\_\_\_ Address Line 2: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

\*Patient Allergies: \_\_\_\_\_ or  none

\*List of Patient's Current Medications: \_\_\_\_\_ or  none

For SPRAVATO® (esketamine): 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.

For PONVORY® (ponesimod): Before initiation of treatment with PONVORY®, you are required to assess the patient's individual needs for completion of pretests. If this has been completed, please check the box below. We are unable to dispense PONVORY® for your patient until this step has been completed.

I attest that I have assessed the following based on individual patient needs: Complete Blood Count, Cardiac Evaluation, Liver Function Tests, Ophthalmic Evaluation, Current or Prior Medications with Immune System Effects, and Vaccinations. This patient is cleared to initiate therapy with PONVORY®.

### 2. HCP Information *(The address you provide here will be used to ship HCP-administered 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): \_\_\_\_\_

**If you are aware of an Assistance Diversion Program (ADP) being part of the patient's plan design, please provide the details below:**

ADP Name: \_\_\_\_\_ Address Line 1: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### 3. HCP Authorization

The prescriber is responsible for ensuring the prescription complies with their state-specific prescription requirements, such as e-prescribing, state-specific prescription form, or fax language. Noncompliance with state-specific requirements could result in outreach to the prescriber.

**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:

\_\_\_\_\_  
 \*Healthcare Provider Signature \*Date (mm/dd/yyyy): \_\_\_\_\_

# 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, have a financial hardship, and are currently enrolled in government, commercial, or employer group health insurance.

You must meet the eligibility and income requirements to qualify for the patient assistance program.

You are not eligible for free Janssen medication if your health insurance will cover the cost of your Janssen-prescribed medication if this application is denied. Some employers, insurers, and other companies force patients to apply for medically necessary medications from free product programs instead of covering such medications directly and immediately through insurance, which could lead to delays in care and discriminate against lower-income patients. These types of "Assistance Diversion Programs" are generally established by companies that profit by diverting resources away from patients in need. An Assistance Diversion Program is any insurer, employer, or third-party program that withholds coverage or payment for Patient's medically necessary drug until Patient has completed an application for free product assistance. Assistance Diversion Programs are prohibited by Janssen to make sure that help is available for patients with no safety net in place. Your insurer must submit a Patient Eligibility Certification form to confirm that your drug coverage is not subject to an Assistance Diversion Program.

You may not seek payment for the value of Janssen medications received from this program from any health plan, patient assistance foundation, flexible spending account, or healthcare savings account.

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

You may end your participation in the program at any time by calling 833-742-0791, Monday through Friday, 8:00 AM to 8:00 PM ET.

