Patient Assistance Program Application

Johnson & Johnson PATIENT ASSISTANCE FOUNDATION, INC.

TO BE COMPLETED BY THE PATIENT

To apply for assistance all information must be complete and include the following steps:

☐ Complete pages 1 and 2 and sign the Patient Declaration and Authorization to Share information on page 2
☐ Ask your Healthcare Professional (HCP) to complete pages 3-4 and sign page 4
☐ Include a copy of your most recent 1040 or 1040EZ federal tax return

Fax to: 1-888-526-5168 **or**
Mail to: Johnson & Johnson Patient Assistance Foundation, Inc.
Patient Assistance Program
P.O. Box 221857, Charlotte, NC 28222-1857
If you have any questions, call 1-800-652-6227

1 Patient Information

Name: _____ Telephone: _____ Email: _____

Social Security #: _____ Date of Birth: _____ Gender: ☐ Male ☐ Female

Address (Street, City, State, ZIP): _____

2 Financial Information

Federal Taxes

☐ A copy of my most recent 1040 or 1040EZ Federal tax return is attached.

☐ I do not file federal taxes.

(Tax returns may be reviewed and additional documentation requested.)

Total Gross Yearly Income

Entire Household: $ _____

Household Size: The number of people who live in your home and are dependent on your household income: _____

3 Healthcare Insurance Information *(Select all that apply.)*

☐ **I do not have healthcare insurance**

☐ **Private/HMO insurance**

Insurance Company: _____

Policy ID #: _____

Group ID #: _____

Phone #: _____

Subscriber Name: _____

Date of Birth: _____

Relation to Patient: _____

Does the policy cover prescription drugs?

☐ Yes
☐ No
☐ Unsure

☐ **Medicare insurance**

Insurance Company: _____

Medicare Policy #: _____

Plan Name: _____

Are you enrolled in a Medicare prescription drug plan?

☐ Yes ☐ No

Part D Policy #: _____

Part D Plan Name: _____

Phone #: _____

☐ **Medicaid insurance**

Policy #: _____

Plan Name: _____

Phone #: _____

☐ **Other state/government insurance**

Veterans Affairs (VA)

Policy #: _____
Plan Name: _____
☐ My application is pending
Phone #: _____

ADAP AIDS Drug Assisted Program

Policy #: _____
Plan Name: _____
☐ My application is pending
☐ I am on a waiting list

SPAP State Patient Assistance Program

Policy #: _____
Plan Name: _____
☐ My application is pending

Other:

Policy #: _____
Plan Name: _____
☐ My application is pending
Phone #: _____

TO BE COMPLETED BY THE PATIENT: Patient should keep a copy of this page

4 Patient Declaration

I promise:

- The information on this form is correct and complete including all copies of documents proving my income.
- The product(s) provided under this patient assistance program will not be sold or traded.
- I will notify the Johnson & Johnson Patient Assistance Foundation, Inc. (JJPAF) Patient Assistance Program within thirty (30) days if there is any change in the status of my eligibility (related to changes in income or health coverage) to receive products through this program. 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.

Patient Authorization To Share Health Information: I allow my doctor(s), any health care providers, and my health plan or insurers to give medical information related to my use or need for products provided under the JJPAF Patient Assistance Program:

I understand:

- This information can include spoken or written facts about my health and payment benefits.
- It can include copies of my health records.
- People who work for JJPAF or the Program Administrator may see my information but they may use it only to help me get assistance with the costs of my drugs and to run the Program.
- Every effort will be made to keep my information private but if it is accidentally given out, federal privacy laws will not protect it.
- JJPAF and the Program Administrators reserve the right without notice to change the application form, change the program or program criteria or stop assistance provided by the program at any time.
- JJPAF may request and obtain information about my or my family's income.
- I can withdraw this consent by contacting JJPAF at 1-800-652-6227 at any time, but it will not change any actions taken before I withdraw consent.
- I have a right to see or copy information given to JJPAF or the Program Administrators.
- Specifically, I authorize JJPAF to contact me to request my assistance with analysis related to the quality and efficacy of the JJPAF program.
- When signing this application, you are agreeing to allow the manufacturer or its agent to contact you or your healthcare provider for additional information, if needed, to evaluate any adverse event or product complaint you or your provider reported on your behalf.
- This Authorization will last until I am no longer participating in the Program.

***I know that I may refuse to sign this form*. My choice about whether to sign this form will not change the way health care providers or insurers treat me. If I refuse to sign this form, I know that this means that I may no longer be able to receive assistance from the Program.**

Patient Name (print): _____ **Patient Signature**: _____
Date

If applicable, your representative or Power of Attorney must sign below.

Patient Representative Name: _____ Signature: _____
Date

Contact information: _____

Relationship to patient and authority to make medical decisions for patient: _____

Power of Attorney Name: _____ **Signature:** _____
Date

Contact information: _____

We will contact you if additional documentation is required.

5 If applicable: Patient Authorization to Elect Representative for Purposes of Program Enrollment

I permit the Johnson & Johnson Patient Assistance Foundation, Inc. (JJPAF) to speak with the following person about my application. This includes discussing the status of my application, insurance and financial questions, any missing documentation and other issues related to my application.

Name of Authorized Representative: _____ Organization Name: _____

Telephone: _____ Email: _____

By signing below, I am allowing this representative to speak on my behalf on any matter regarding my application with JJPAF.

Patient Signature: _____
Date

TO BE COMPLETED BY THE HEALTHCARE PROFESSIONAL (HCP)

1 **Products to be distributed** (Select all that apply). This program is limited to patients being treated on an **outpatient basis**.

Patient Name: _____

		Pharmacy Card Pharmacy pick up. HCP must provide a prescription.	**Direct to HCP** Shipped to the HCP's office.	**Direct to Patient** Shipped to the patient's residence.
AXERT® (almotriptan malate)	Tablets	☐	N/A	N/A
CONCERTA®† (methylphenidate HCl)	Extended-release tablets CII	☐	N/A	N/A
DARZALEX™ (daratumumab)	Injection for intravenous infusion	N/A	☐	N/A
DITROPAN® XL (oxybutynin chloride)	Extended-release tablets	☐	N/A	N/A
DOXIL®† (doxorubicin HCl liposome)	Intravenous infusion	N/A	☐	N/A
DURAGESIC®† (fentanyl)	Transdermal system CII	☐	N/A	N/A
EDURANT® (rilpivirine)	Tablets	☐	☐	N/A
ELMIRON® (pentosan polysulfate sodium)	Capsules	☐	N/A	N/A
HALDOL®† (haloperidol)	Injection for immediate-release	N/A	☐	N/A
HALDOL®† Decanoate (haloperidol)	Injection for extended-duration for effect	N/A	☐	N/A
IMBRUVICA® (ibrutinib)	Capsules	N/A	N/A	☐
INTELENCE® (etravirine)	Tablets	☐	☐	N/A
INVEGA®† (paliperidone)	Extended-release tablets	☐	☐	N/A
INVEGA SUSTENNA®† (paliperidone palmitate)	Extended-release injectable suspension	N/A	☐	N/A
INVEGA TRINZA™† (paliperidone palmitate)	Extended-release injectable suspension	N/A	☐	N/A
INVOKAMET® (canagliflozin + metformin)	Tablets	☐	N/A	N/A
INVOKANA® (canagliflozin)	Tablets	☐	N/A	N/A
LEVAQUIN®† (levofloxacin)	☐ Tablets or ☐ Oral solution	☐	N/A	N/A
MONOVISC® (high molecular weight hyaluronan)	Injection	N/A	☐	N/A
NATRECOR® (nesiritide)	Intravenous infusion	N/A	☐	N/A
NUCYNTA® (tapentadol)	Immediate-release tablets CII	☐	N/A	N/A
NUCYNTA® ER† (tapentadol)	Extended-release oral tablets CII	☐	N/A	N/A
OLYSIO® (simeprevir)	Capsules	☐	N/A	N/A
ORTHOVISC® (high molecular weight hyaluronan)	Injection	N/A	☐	N/A
PANCREAZE® (pancrelipase)	Delayed-release capsules	☐	☐	N/A
PARAFON FORTE® DSC (chlorzoxazone)	Caplets	N/A	☐	N/A
PREZCOBIX™ (darunavir 800mg/cobicistat 150mg)	Tablets	☐	☐	N/A
PREZISTA® (darunavir)	Tablets	☐	☐	N/A
PREZISTA® (darunavir)	Oral Suspension	☐	N/A	N/A
PROCRIT®† (epoetin alfa) Required: Is the patient being treated on renal dialysis?	Injection ☐ Yes* ☐ No	☐	☐	N/A
RAZADYNE® (galantamine HBr)	☐ Tablets or ☐ Oral solution	☐	N/A	N/A
RAZADYNE® ER (galantamine HBr)	Extended-release capsules	☐	N/A	N/A
REMICADE®† (infliximab)	Intravenous Infusion	N/A	☐	N/A
RISPERDAL®† (risperidone)	☐ Tablets or ☐ Oral solution	☐	☐	N/A
RISPERDAL CONSTA®† (risperidone)	Long-acting injection	N/A	☐	N/A
RISPERDAL® M-TAB®† (risperidone)	Orally disintegrating tablets	☐	☐	N/A
SIMPONI®† (golimumab)	☐ SmartJect® or ☐ prefilled syringe	☐	N/A	N/A
SIMPONI ARIA®† (golimumab)	Intravenous Infusion	N/A	☐	N/A
SPORANOX®† (itraconazole)	Capsules	☐	N/A	N/A
SPORANOX®† (itraconazole)	Oral solution	N/A	☐	N/A
STELARA® (ustekinumab)	Injection	☐	☐	N/A
SYLVANT® (siltuximab)	Intravenous Infusion	N/A	☐	N/A
TERAZOL® 3 (terconazole)	Cream	N/A	☐	N/A
TERAZOL® 7 (terconazole)	Cream	N/A	☐	N/A
TOPAMAX® (topiramate)	☐ Tablets or ☐ Sprinkle capsules	☐	N/A	N/A
ULTRACET®† (tramadol HCl/acetaminophen)	Tablets CIV	☐	N/A	N/A
ULTRAM® (tramadol HCl)	Tablets CIV	☐	N/A	N/A
ULTRAM® ER (tramadol HCl)	Extended-release tablets CIV	☐	N/A	N/A
XARELTO®† (rivaroxaban)	Tablets	☐	N/A	N/A
YONDELIS® (trabectedin)	Injection for intravenous infusion	N/A	☐	N/A
ZYTIGA® (abiraterone acetate)	Tablets	☐	N/A	N/A

*Contact Amgen Inc. 1-800-772-6436. † See full U.S. prescribing information, including Black Box warning. Revised: November 2015

TO BE COMPLETED BY THE HEALTHCARE PROFESSIONAL (HCP)

2 Prescription *(if requesting more than 2 products, attach additional prescription information.)*

Patients eligible for the program can receive **up to 12 months** of assistance as long as they continue to meet eligibility requirements.

Medication #1

Patient Name: _____

ICD Code *(HCP administered products only)*: _____

Name of product: _____

Dosage: _____ Sig: _____

Quantity: _____ Days supply: _____

Number of Refills *(maximum 11)*: _____

Medication #2

Patient Name: _____

ICD Code *(HCP administered products only)*: _____

Name of product: _____

Dosage: _____ Sig: _____

Quantity: _____ Days supply: _____

Number of Refills *(maximum 11)*: _____

If you are requesting IMBRUVICA®:

List any patient allergies: _____ **or** ☐ NKDA

List current therapy and medications: _____ **or** ☐ none

For New York State Prescribers, attach order for **IMBRUVICA®** on your NYS official prescription form.

If you are requesting PROCRIT®†: What is the hemoglobin level based on most recent lab results? _____

If you are requesting HIV medication: Is patient currently on ☐ **PREZISTA®** ☐ **PREZCOBIX™** ☐ **INTELENCE®** ☐ **EDURANT®**?

If you are requesting OLYSIO® indicate the length of therapy: ☐ 12 weeks or ☐ 24 weeks

3 HCP Information

Name: _____ Site: _____ Site Contact: _____

Address (City, State, ZIP): _____ Business Hours: _____

Telephone: _____ Fax: _____ Email address: _____

Tax ID #: _____ National Provider ID #: _____

State License # *(required)*: _____ DEA # *(required* for controlled substances*)*: _____

4 Direct to HCP Distribution *(Complete only if the shipping address is different from the HCP information section.)*

Site: _____ Contact Name for Shipment: _____

Business Hours: _____ Telephone: _____ Fax: _____

Address (City, State, ZIP): _____

Please note, Florida HCPs may be required to provide Florida Pedigree information at time of first shipment.

Johnson & Johnson Patient Assistance Foundation, Inc. (JJPAF) policy prohibits Healthcare Professionals (HCPs) from charging patients any fee for enrollment or other activities associated solely with the patient's participation in this patient assistance program (Program).

- JJPAF requests that HCPs not charge the patient for those professional services associated with this regimen not covered by the patient's health insurer.
- No claim may be made to any third party payer (e.g., Medicaid, Medicare, private insurance, etc.) for payment for product provided under the Program.
- The products(s) provided under this patient assistance program may not be sold or traded and may not be returned for credit.
- This program is limited to patients being treated on an outpatient basis.

Indicate your agreement to the terms of Program participation by signing below. Your signature is intended to confirm to JJPAF:

- There is a valid medical need for this patient's prescription.
- That to the best of your knowledge this patient does not have prescription drug insurance coverage (including Medicare, Medicaid, county funded, or other public programs) for the product(s) listed above.
- You are not prohibited from participating in Federally-funded health care programs nor are you on the List of Excluded Individuals/Entities maintained by the HHS Office of Inspector General.

Healthcare Professional Signature: _____ **Date:** _____

† See full U.S. prescribing information, including Black Box warning.

Revised: November 2015

