NOTE: Please read the Patient Eligibility Requirements on the next page prior to completing this form.

UPDATE 10.15

RemiStart® Patient Rebate Program

2016 Patient Enrollment Form

Remicade® INFLIXIMAB

SELECT ONE: ☐ Enrollment ☐ Update Information Only

Phone: 1-888-ACCESS-1 (1-888-222-3771) Fax: 877-234-3048 **www.RemiStart.com**

PATIENT INFORMATION

NAME _____ GENDER ☐ Male ☐ Female DATE OF BIRTH (MM/DD/YYYY) _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

PRIMARY PHONE (Best number to call 8:00 AM–8:00 PM ET weekdays) _____ E-MAIL _____

If you're unavailable when we call, is it ok for us to leave a message including the prescription name REMICADE®? ☐ Yes ☐ No

The rebate for REMICADE® medication will be placed on a MasterCard® Rebate Debit Card to pay for medication at infusion provider. If you prefer, a check (in your name) can be sent directly to your infusion provider or directly to you by checking one of the following boxes. ☐ MAIL CHECK TO INFUSION PROVIDER ☐ MAIL CHECK TO ME

1. Do you currently have private or commercial health insurance that covers at least a portion of your medication costs for REMICADE®, including insurance provided through an employer or former employer, insurance you pay for yourself, as well as plans available through state and federal healthcare exchanges?
   - ☐ **Yes**, I have private or commercial health insurance that I will use for REMICADE®
   - ☐ **No**, I do not have private or commercial health insurance that I will use for REMICADE®

2. Do you confirm that you will NOT seek reimbursement for REMICADE® from any state- or federal-government-subsidized healthcare program that could cover a portion of your medication costs for REMICADE®, such as those listed below?
   - Medicare Part A • Medicare Part B
   - Medicare Part C (Medicare Advantage Plan) • Medicare Part D • Medicaid
   - TRICARE • Department of Defense or Veterans Administration
   - ☐ **Yes**, I confirm that I will NOT seek reimbursement for REMICADE® from any state- or federal-government-subsidized healthcare programs
   - ☐ **No**, I cannot confirm that I will NOT seek reimbursement for REMICADE® from any state- or federal-government-subsidized healthcare programs

3. Do you confirm that you will NOT seek reimbursement for medication costs for REMICADE® from any other program, such as those listed below?
   - Pharmaceutical patient assistance foundations
   - A Flexible Spending Account (FSA)
   - A Healthcare Savings Account (HSA)
   - A Health Reimbursement Account (HRA)
   - ☐ **Yes**, I confirm that I will not seek reimbursement for REMICADE® costs from any other programs
   - ☐ **No**, I cannot confirm that I will NOT seek reimbursement for REMICADE® costs from any other programs

By submitting this form, I am requesting to be enrolled in the RemiStart® Patient Rebate Program for REMICADE® (the "Program"). I understand that my personal information will be used by Janssen Biotech, Inc., the maker of my medication, including our affiliates and our service providers that work on their behalf (the"Companies"), in connection with the Program, to help me get assistance with the costs of my REMICADE® medication, or as otherwise required or allowed under the law. I also understand that the Companies may use my name and contact information for market and outcomes research and to improve the information that the Companies provide to patients who are being treated with REMICADE®. I understand that the Companies may de-identify my information and use or disclose the de-identified information for any purpose permitted by law. I understand that they will take commercially reasonable efforts to keep my information private.

I understand that the Companies may contact me by telephone, postal mail, or email (if I provide an email), in connection with my enrollment in the Program. I understand and agree that by enrolling in the Program I may also enroll in the services provided by AccessOne®, a Janssen Biotech, Inc., support program for my medication and other Janssen Biotech, Inc., products. If I choose to participate, these services may include providing educational materials related to my treatment. AccessOne® will also contact my doctor as necessary to administer these services.

I understand that my doctor or I will need to submit my Explanation of Benefits (EOB) or pharmacy receipt to the Program following each infusion. The Program will use the information my doctor or I submit to determine the amount of costs for REMICADE® that Janssen Biotech, Inc., will reimburse. That amount will be credited to my RemiStart® MasterCard® Rebate Card. I further understand that if my doctor or I do not submit an EOB or pharmacy receipt, the Program cannot process my rebate request. I understand that if my insurance information changes, I will need to notify the Program. I understand that AccessOne® and the Program will share Program-related information with my doctor and infusion provider.

I understand that I can cancel participation in the Program at any time by notifying AccessOne® at 888-ACCESS-1 (888-222-3771). Our Privacy Policy, available at www.janssenbiotech.com/privacy-policy, governs the use of the information you provide. I understand that, if I am enrolled in the Program, Janssen Biotech, Inc., will not be responsible for lost or stolen rebate cards or for any misuse of these rebate cards.

INSURANCE INFORMATION – PRIVATE OR COMMERCIAL INSURANCE IS AN ELIGIBILITY REQUIREMENT FOR THIS PROGRAM

Complete this section or provide a copy of the front and back of your insurance card(s). For help in completing this section, see example insurance card on next page.

*Required

*PRIMARY INSURANCE CO NAME _____ *PRESCRIPTION INSURANCE NAME _____

*PRIMARY INSURANCE CO PHONE _____ *PHARMACY SERVICES PHONE (see back of card) _____

*MEDICAL GROUP NUMBER _____ *GROUP # _____

*PAYER ID # (see back of card) _____ POLICY ID # _____ *BIN # _____

POLICYHOLDER NAME _____ *PCN # _____

RELATIONSHIP TO POLICYHOLDER _____

Fax or mail this completed enrollment form to RemiStart®: Fax: 877-234-3048 Mail: Patient Rebate Program, 14001 Weston Parkway, Suite 103, Cary, NC 27513

My signature below certifies that I have completed all of the above sections completely, accurately, and to the best of my knowledge, and that I have read, understand, and agree to the Patient Authorization to release my Protected Health Information as indicated on the next page of this form, including but not limited to spoken or written facts about my health and payment benefits that I may have. It can include copies of records from my healthcare providers or health plans about my health or health care. I understand, accept, and comply with all requirements and restrictions described in the eligibility requirements provided on the next page and I understand that redeeming this rebate is consistent with the requirements of my health plan.

PATIENT SIGNATURE _____ DATE _____ PATIENT NAME _____

If the patient cannot sign, patient's personal representative must sign below (Please print)

PATIENT NAME _____ BY _____

(Signature of person signing for patient)

RELATIONSHIP TO PATIENT AND AUTHORITY TO MAKE MEDICAL DECISIONS FOR PATIENT _____

YOUR PRESCRIBER (Required)

PRESCRIBER NAME _____ PRACTICE NAME _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

PHONE # (Required) _____ OFFICE–MAIN FAX # _____

TREATMENT PROVIDER INFORMATION (This section does not need to be completed if information is the same as "YOUR PRESCRIBER")

NAME OF PHYSICIAN _____ OFFICE/HOSPITAL/OTHER NAME _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

PHONE # (Required) _____ OFFICE–MAIN FAX # _____

☐ Non-prescribing MD's office ☐ Hospital Outpatient ☐ Home Infusion/Infusion Provider Company ☐ Other

Please select to read the full Product Information, including Boxed Warnings and Medication Guide for REMICADE® and discuss any questions you have with your doctor.

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For assistance or additional information, call 888-ACCESS-1 (888-222-3771), Monday–Friday, 8:00 AM–8:00 PM ET.

Patient Authorization (PA)

Patients must read this and sign the acknowledgment on the previous page before they can participate in the Program.

My signature on the previous page of this form confirms that I allow my doctor(s), any other healthcare providers, specialty pharmacy providers, and my health plan or insurers to share medical information relating to my use or potential use of REMICADE® (infliximab) with Janssen Biotech, Inc., including our affiliates and our service providers that work on their behalf, in connection with the Program (the "Companies").

The Companies administer AccessOne® and RemiStart® (the "Program") for Janssen Biotech, Inc., maker of REMICADE®.

This information can include spoken or written facts about my health and payment benefits I may have. It may include copies of records from my healthcare providers or health plans about my health or health care.

The Companies may use and share this information to help find alternate funding sources for REMICADE®, and perform other related services. The Companies may also share my information with other related parties of this program or as otherwise set forth above.

The Companies will use and share this information to see if I qualify for the Programs and to run the Programs. In addition, the Companies may use and share my information to refer me to other programs, foundations, or alternate sources of funding or coverage that may be available to provide assistance to me with costs of my medication. Program management employees of the Companies may also see my information, but they may use it only in connection with the Program, to help me get assistance with the costs of my medication, or as otherwise required or allowed under the law. I understand that they will make every effort to keep my information private, but if it is accidentally shared with an associated party, federal privacy laws will not protect it.

This Authorization will last until I am no longer participating in the Program. If I change my mind, I can inform my healthcare providers and my insurers in writing that I do not want them to share any information with AccessOne® and RemiStart® (Janssen Biotech, Inc., including our affiliates and our service providers that work on their behalf, in connection with the Program), but will not change any information shared before I notified them of my desire to discontinue. I know that I have a right to see or copy the information my healthcare providers or insurers have given to the Companies.

I understand that I am not required to sign this form on the previous page. My choice about whether to sign this form will not change the way my healthcare providers or insurers treat me. If I refuse to sign on the previous page of this form, I know that this means I will not be able to receive assistance from the Program.

Patient Eligibility Requirements for the RemiStart® Program

RemiStart® is available to patients who:

- Are beginning or are currently receiving treatment with REMICADE®
- Currently have private or commercial health insurance that covers a portion of the medication costs for REMICADE®

Other Restrictions:

- This program is only available to individuals using private or commercial health insurance to cover a portion of their medication costs, including plans available through state and federal health care exchanges. This program is not available to individuals who use any state- or federal-government-subsidized healthcare program to cover a portion of medication costs, such as Medicare, Medicaid, TRICARE, Department of Defense, or Veterans Administration. Patients confirm that they will not seek reimbursement from any of these programs or from pharmaceutical patient assistance foundations and accounts such as a Flexible Spending Account (FSA), Healthcare Savings Account (HSA) or Health Reimbursement Account (HRA)
- This offer may not be combined with any other coupon, discount, prescription savings card, free trial, or other offer
- The selling, purchasing, trading, or counterfeiting of this rebate card is prohibited
- Offer good only in the U.S. and Puerto Rico. Janssen Biotech, Inc. reserves the right to rescind, revoke, or amend this offer without notice at any time. Void where prohibited, taxed, or otherwise restricted by law
- Offer for new enrollment expires December 31, 2016. For Massachusetts residents only, this offer is subject to change per state legislation
- This program is not retroactive

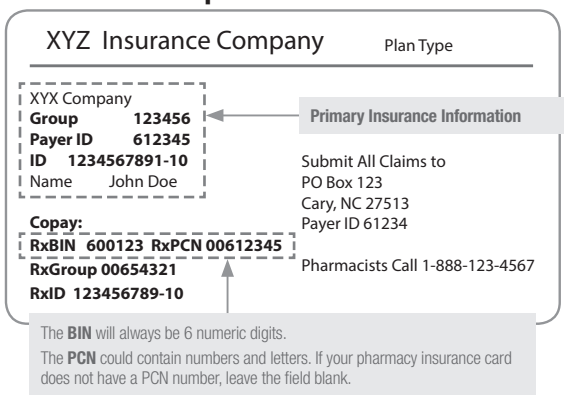
How can I enroll?

1. Review the eligibility requirements above. Complete and sign the first page of this form.
2. Fax or mail this enrollment form to RemiStart®
   Fax: 877-234-3048
   Mail: Patient Rebate Program, 14001 Weston Parkway, Suite 103, Cary, NC 27513

NOTE: Your signature on the first page of this form certifies:

- That you understand, accept, and comply with all requirements and restrictions described above, and that redeeming this rebate is consistent with the requirements of your health plan.
- That you have read, understand, and agree to the Patient Authorization to release your Protected Health Information as indicated above, including but not limited to spoken or written facts about your health and payment benefits you may have. It can include copies of records from your healthcare providers or health plans about your health or health care.

Example Insurance Card



Please select to read the full Prescribing Information, including Boxed Warnings and Medication Guide for REMICADE®, and discuss any questions you have with your doctor.

Janssen Biotech, Inc., is not liable for unintended or unauthorized use of the RemiStart® Patient Rebate Program MasterCard® Rebate Card if it is lost or stolen. This card is issued by MetaBank®, Member FDIC, pursuant to license by MasterCard International. MasterCard is a registered trademark of MasterCard International. RemiStart® is not a MetaBank product and is not endorsed by them.

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