Janssen CarePath UPDATE 11.21

Benefits Investigation Form

Complete and fax this form to 866-836-0567 or mail to
2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560
For assistance, call 877-CarePath (877-227-3728),
Monday–Friday, 8:00 AM–8:00 PM ET

PREZISTA® (darunavir) tablets | PREZCOBIX® (darunavir 800 mg/cobicistat 150 mg) tablets | Symtuza® darunavir/cobicistat/emtricitabine/tenofovir alafenamide tablets 800mg/150mg/200mg/10mg
EDURANT® (rilpivirine) tablets | INTELENCE® (etravirine) tablets

Janssen CarePath cannot accept any information without an executed Business Associate Agreement or Patient Authorization Form, which can be found at JanssenCarePath.com or as the last 2 pages of this document. The information you provide will be used by Janssen Therapeutics, Division of Janssen Products, LP, our affiliates, and our service providers for your patient's enrollment and participation in Janssen CarePath. Our Privacy Policy governs the use of the information you provide. By submitting this form, you indicate that you read, understand, and agree to these terms.

1. Patient Information

PATIENT NAME _____ DOB (MM/DD/YYYY) _____ ☐ MALE ☐ FEMALE

NAME OF GUARDIAN (IF APPLICABLE) _____

PATIENT ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

PRIMARY PHONE _____ SECONDARY PHONE _____

2. Insurance Information

PRIMARY INSURANCE _____

PRIMARY INSURANCE PHONE _____

CARDHOLDER _____

CARDHOLDER DOB (MM/DD/YYYY) _____

RELATIONSHIP TO CARDHOLDER _____

POLICY# _____ GROUP# _____

PROVIDER ID # FOR INSURANCE _____

SECONDARY INSURANCE _____

SECONDARY INSURANCE PHONE _____

CARDHOLDER _____

CARDHOLDER DOB (MM/DD/YYYY) _____

RELATIONSHIP TO CARDHOLDER _____

POLICY# _____ GROUP# _____

PROVIDER ID # FOR INSURANCE _____

RX CARD PATIENT ID _____

3. Prescriber Information

NAME OF FACILITY _____ FACILITY TAX ID # _____

PROVIDER TRANSACTION ACCESS # (PTAN) _____ PHYSICIAN MEDICAID PROVIDER ID # _____

NAME OF PHYSICIAN _____ SPECIALTY _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

PHONE _____ FAX _____

OFFICE CONTACT _____ OFFICE CONTACT PHONE _____

TAX ID # _____ NPI # _____

4. Drug Therapy

VERIFY BENEFITS FOR: ☐ SYMTUZA® ☐ PREZISTA® ☐ PREZCOBIX® ☐ EDURANT® ☐ INTELENCE® DOSING _____ MG

DIAGNOSIS CODE: _____

ADDITIONAL INFORMATION REGARDING TREATMENT (IF APPLICABLE TO BENEFITS VERIFICATION)

_____

5. 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 Preparation** 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 the product noted in the Drug Therapy portion of this form. 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 to the health plan.

☐ **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 the product noted in the Drug Therapy portion of this form.

Information about your patient's insurance coverage, cost support options, and treatment support is given by service providers for Janssen CarePath. The information you get does not require you or your patient to use any Janssen product. Because the information we give you comes from outside sources, Janssen CarePath cannot promise the information will be complete. Janssen CarePath is not for patients in the Johnson & Johnson Patient Assistance Foundation.

Please see full Prescribing Information, including Boxed Warning and Patient Information, for SYMTUZA®. Provide the Patient Information to your patients and encourage discussion.

Please see full Prescribing Information for PREZISTA®, PREZCOBIX®, EDURANT®, and INTELENCE®.

Janssen Patient Support Program
Patient Authorization Form

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

- **Download a copy, print, check the desired boxes, and sign. Your healthcare provider may scan the completed Form and upload on Provider Portal, or completed Form may be faxed to 866-836-0567 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 healthcare provider's office or on the Janssen CarePath Patient Account at MyJanssenCarePath.com**

Patient Name: _____ **Email Address:** _____

I give permission for each of my "Healthcare Providers" (eg, my physicians, pharmacists, specialty pharmacies, other healthcare providers, 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 healthcare providers 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 Healthcare Providers regarding access to, reimbursement for, and fulfillment of my Janssen medication, and to tell my Healthcare Provider that I am participating in Janssen patient support programs
- verify, assist with, and coordinate my coverage for my Janssen medication with my Insurers and Healthcare Providers
- 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 Healthcare Providers
- 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 Patient Support Program
Patient Authorization Form

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.

I understand that I am not required to sign this Form. My choice about whether to sign will not change how my Healthcare Providers 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 my Healthcare Providers may be paid by Janssen for sharing my Protected Health Information with Janssen 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 Healthcare Providers 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: _____

Patient name (print): _____

Patient sign here: _____ **Date:** _____

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

By: _____ **Date:** _____

(Signature of person legally authorized to sign for patient)

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

_____