Janssen CarePath UPDATE 09.23

Akeega™ (niraparib/abiraterone acetate) 100mg/500mg tablets • 50mg/500mg tablets

Erleada® (apalutamide) 60 mg tablets 240 mg tablet

Pharmacy Benefits Investigation Form

Fax the completed and signed Pharmacy Benefits Investigation Form to Janssen CarePath at 855-998-4422.
For assistance, call 877-CarePath (877-227-3728), Monday–Friday, 8:00 AM–8:00 PM ET

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 Biotech, Inc., 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 (Required)

FIRST NAME _____ MI _____ LAST NAME _____ PREFERRED LANGUAGE ☐ English ☐ Spanish ☐ Other

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

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PRIMARY PHONE _____ SECONDARY PHONE (Optional) _____ BEST TIME TO CONTACT _____

CAREGIVER/CONTACT _____ PHONE _____ BEST TIME TO CONTACT _____
(A caregiver/contact is someone who can be contacted in place of the patient)

☐ I authorize Janssen CarePath to leave a message, including the name of the Janssen medication indicated on this form, if I am unavailable when they call.

☐ If I cannot be reached, I authorize Janssen CarePath to contact my caregiver.
☐ I prefer and authorize Janssen CarePath to contact my caregiver in place of me.

Please sign the Patient Authorization on pages 3-4.

2. PRESCRIPTION DRUG INSURANCE INFORMATION (Required) Please provide information on insurance coverage for prescription drugs (pharmacy benefits).

☐ Please see attached front and back copy of insurance card. ☐ Please investigate out-of-network benefits.

PRESCRIPTION DRUG INSURANCE _____ CARD BIN # _____ PHONE _____

CARDHOLDER NAME (FIRST, MI, LAST) _____ RELATIONSHIP TO CARDHOLDER _____ POLICY # _____ GROUP # _____

3. PRESCRIBER INFORMATION (Required)

FIRST NAME _____ LAST NAME _____ SPECIALTY _____

PRACTICE NAME _____ OFFICE CONTACT NAME _____

OFFICE CONTACT PHONE _____ OFFICE CONTACT FAX _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____ EMAIL _____

MEDICAID/MEDICARE PROVIDER # _____ TAX ID # _____

STATE LICENSE # _____ UPIN/NPI # _____ ICD-10 DIAGNOSIS CODE(S) _____

As the treating physician, I have discussed preference for a Specialty Pharmacy (SP) with this patient. This patient prefers use of the SP indicated below. I authorize Janssen Biotech, Inc., and its representatives to fax this prescription to: **1.** The SP designated below, provided it is approved by this patient's plan. **2.** If the SP designated is not a plan-approved SP, then to an SP approved by this patient's plan. **3.** If there is no preferred SP indicated, then to any SP approved by this patient's plan.

Please check one:

☐ Preferred Specialty Pharmacy (ERLEADA® Only) _____

☐ ONCO360 (AKEEGA™ Only)

☐ Self-Dispensing Pharmacy (Please check this box if you are a self-dispensing pharmacy.)

☐ I do **NOT** wish to authorize prescription triage to SP.

4. PRIOR AUTHORIZATION (Optional) Automatically provided with benefits investigation. You may opt out by checking the box below.

PRIOR AUTHORIZATION FORM ASSISTANCE AND STATUS MONITORING: Janssen CarePath* assists your office in providing the requirements of the patient's health plan related to prior authorization for treatment with the medication specified on this form. Assistance includes obtaining the health-plan-specific prior authorization form and providing it based upon the patient-specific information provided on this form. The partially completed prior authorization form, if received from the health plan, will be provided to your office for possible completion and submission in the office's sole discretion. Janssen CarePath also actively monitors the status of prior authorization submission to the patient's plan and provides status updates to your office with respect to this patient's prior authorization for treatment with the medication specified on this form.

*Prior authorization support for AKEEGA™ is provided by ONCO360.

☐ I do **NOT** wish to receive Prior Authorization Form Assistance or Status Monitoring.

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 cost support is not for patients in the Johnson & Johnson Patient Assistance Foundation.

Please read full Prescribing Information for AKEEGA™ and ERLEADA®.

Clear Form Print Form

Janssen CarePath

Akeega™ (niraparib/abiraterone acetate) 100mg/500mg tablets • 50mg/500mg tablets

Erleada® (apalutamide) 60 mg tablets 240 mg tablet

Pharmacy Benefits Investigation Form

5. PRESCRIPTION INFORMATION: TO BE COMPLETED BY PHYSICIAN (Optional) For Triage to Pharmacy – If requesting benefits investigation only, do not complete this section.

PATIENT NAME (First, MI, Last) _____ DATE OF BIRTH _____

Rx ERLEADA® ☐ 60 mg Tablets ☐ 240 mg Tablet

DIRECTIONS: Take _____ mg PO _____ daily with or without food. QUANTITY _____ REFILLS # _____

Rx AKEEGA™ ☐ 50 mg/500 mg Tablets ☐ 100 mg/500 mg Tablets

DIRECTIONS: Take _____ mg / _____ mg PO _____ daily. QUANTITY _____ REFILLS # _____

PRESCRIBER NAME (if different from page 1) _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____ FAX _____

PRESCRIBER SIGNATURE (NO STAMPS) REQUIRED. I certify that therapy with the Janssen medication indicated above is medically necessary for this patient. I will be supervising the patient's treatment accordingly, and I have reviewed the current full Prescribing Information for the Janssen medication indicated above. I authorize Janssen CarePath to act on my behalf for the limited purposes of transmitting this prescription to the appropriate pharmacy designated by me, the patient, or the patient's plan.

PRESCRIBER SIGNATURE >> (Dispense as written) _____ DATE _____

PRESCRIBER SIGNATURE >> (Substitutions allowed) _____ DATE _____

SUPERVISING PHYSICIAN SIGNATURE >> (If applicable) _____ DATE _____

SUPERVISING PHYSICIAN NAME _____

6. JANSSEN CAREPATH SAVINGS PROGRAM (Optional)

Eligible patients using commercial insurance can save on out-of-pocket Janssen medication costs. See program requirements at JanssenCarePath.com.

☐ I would like Janssen CarePath to check the patient's eligibility for and enroll the patient into the Janssen CarePath Savings Program if the results of this benefits investigation determine that the patient has commercial or private health insurance.

ELIGIBILITY QUESTIONS

1. Will the patient use commercial or private health insurance for their Janssen medication? (Examples are commercial insurance from a current/former employer, government employee health insurance, or insurance the patient buys privately or through the Health Insurance Marketplace.)
   - ☐ **YES,** the patient has commercial or private health insurance that they will use for their Janssen medication
   - ☐ **NO,** the patient does not have commercial or private health insurance that they will use for their Janssen medication
2. Do you confirm the patient will NOT ask any government-funded healthcare program to cover any Janssen medication costs? (Examples are Medicare Parts A, B, C (also known as Medicare Advantage Plan), D, and Medicare Supplement, Medicaid, TRICARE, Department of Defense, or Veterans Administration.)
   - ☐ **YES,** I confirm the patient will NOT seek payment from any government-funded healthcare program for their Janssen medication
   - ☐ **NO,** the patient may seek payment from a government-funded healthcare program for their Janssen medication
3. Do you confirm the patient will NOT submit any costs paid by this program as a claim for payment to any health plan, patient assistance foundation, flexible spending account, or healthcare savings account?
   - ☐ **YES,** I confirm that the patient will NOT submit out-of-pocket costs paid by this program as a claim
   - ☐ **NO,** the patient may submit out-of-pocket costs paid by this program as a claim

7. *JANSSEN COMPASS®* (Optional)

All eligible patients will be contacted by a Care Navigator through the *Janssen Compass®* program.*

Janssen Compass® is a free, personalized patient support program that offers patients access to a dedicated Care Navigator who will provide one-on-one guidance over the phone. See terms and conditions at **JanssenCompass.com/signup**. A Care Navigator will contact the patient within 1 business day unless you select the check box below to opt your patient out. If you would like to speak with a Care Navigator immediately, please call 844-628-1234, Monday–Friday, 8:30 AM–8:30 PM ET.

☐ I would **NOT** like my patient to be contacted by a Care Navigator to learn how *Janssen Compass®* may be able to provide additional education and support.

**Janssen Compass®* is limited to education for patients about their Janssen therapy, its administration, and/or their disease. It is intended to supplement a patient's understanding of their therapy and is not intended to provide medical advice, replace a treatment plan from the patient's doctor or nurse, provide case management services, or serve as a reason to prescribe a Janssen medication.

Please read full Prescribing Information for AKEEGA™ and ERLEADA®.

Clear Form Print Form

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 the 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 855-998-4422 or mailed to Janssen CarePath, 2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560**

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

Clear Form Print Form

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 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 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: _____ **Print Name:** _____ **Date:** _____

(Signature of person legally authorized to sign for patient)

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

_____

Clear Form Print Form