Patient Assistance Program Application

Johnson & Johnson PATIENT ASSISTANCE FOUNDATION, INC.

The Johnson & Johnson Patient Assistance Foundation, Inc. (JJPAF) is an independent, non-profit organization that is committed to helping eligible patients without insurance coverage receive prescription products donated by Johnson & Johnson operating companies.

Patients who meet program requirements may be able to receive their medications for up to one year. It's free to apply and you only need to complete one application.

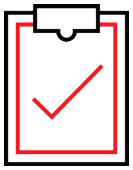
Who may be eligible for the program?

You may be eligible for our free prescription program if you meet the requirements below:

- You have been prescribed a Johnson & Johnson operating company donated medication
- You meet the eligibility income requirements for the medication(s). You may view the income requirements on our website at www.jjpaf.org/eligibility/requirements.html
- You don't have insurance or medicine is not covered
  - Some patients with Medicare Prescription Drug Coverage (Part D) who cannot afford their medicines and who meet certain financial criteria may also be eligible for assistance
    - 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 can be requested and may be submitted with your application. In order to qualify for the program, you must spend 4% or more of **your** gross annual income on prescription drugs
- You live in the United States or a U.S. Territory
- You are being treated by a U.S. licensed doctor as an outpatient

Checklist for submitting an application:

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



Patient Information:

- Complete all relevant information on pages 1 and 2, and **sign and date** the Patient Declaration and Authorization to Share Information on page 2
- Include a copy of the **front and back** of your insurance card
- Include a copy of your most recent 1040 or 1040EZ Federal tax return

Healthcare Professional Information:

- Ask your Healthcare Professional (HCP) to complete pages 3-4 and **sign and date** page 4
- Mail or fax your complete application with documentation

Missing information and/or required documents may delay processing of application.

How do I apply?

Mail or fax the completed application to:

Johnson & Johnson Patient Assistance Foundation, Inc.
Patient Assistance Program
PO Box 42796
Cincinnati, OH 45242

Phone: 1-800-652-6227
Fax: 1-888-526-5168

If you have questions about JJPAF or how to complete the following form, please contact the Foundation at 1-800-652-6227, 9am – 6pm EST, Monday through Friday

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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 the **front and back** of your insurance card
- ☐ 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
PO Box 42796, Cincinnati, OH 45242

If you have any questions, call 1-800-652-6227.

Missing information and/or required documents may delay processing of application.

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. *Not required for SIRTURO® applications.*

☐ 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.)* Please attach a copy of the patient's insurance card.

☐ **No insurance** ☐ **Private/HMO insurance** ☐ **Medicaid**

☐ **Medicare:** ☐ Part A ☐ Part B ☐ Part D ☐ Medicare Advantage

☐ **Other state/government insurance:** ☐ VA ☐ ADAP AIDS ☐ SPAP State Patient Assistance Program ☐ Other
☐ Application is pending ☐ I'm on a wait list (ADAP AIDS)

Do you have prescription drug insurance? ☐ Yes ☐ No

Prescription Insurance/Part D Plan			
Plan Name:		Phone:	Fax:
ID/Policy #:	Rx BIN:	Rx Group #:	Rx PCN:
Subscriber Name:	Date of Birth:	Relationship to Patient:	
Primary Insurance			
Plan Name:			
Phone:	ID/Policy #:	Group #:	
Subscriber Name:	Date of Birth:	Relationship to Patient:	
Secondary Insurance			
Plan Name:			
Phone:	ID/Policy #:	Group #:	
Subscriber Name:	Date of Birth:	Relationship to Patient:	

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.
- Not to attempt to claim or submit any costs associated with the medicine(s) I receive under the Johnson & Johnson Patient Assistance Foundation, Inc. Patient Assistance Program to any person or entity, including my Medicare Part D plan.
- Not to 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.

I authorize the following communications:

- 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, I am agreeing to allow the manufacturer or its agent to contact me or my healthcare provider for additional information, if needed, to evaluate any adverse event or product complaint I or my provider reported on my behalf.

Patient Authorization To Share Health Information: I allow my doctor(s), any healthcare 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, the Program Administrator or agents of JJPAF 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.
- I authorize the JJPAF Program to contact my insurer, other potential funding sources, including the Centers for Medicare and Medicaid Services, social workers or patient advocacy organizations on my behalf in order to determine if I am eligible for health insurance coverage or other funds, and disclose to them information contained in my JJPAF Program application or information about my prescribed medications and medical condition that has been provided by my physician, healthcare provider or pharmacist.
- 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.
- At any time, I can revoke this consent by contacting JJPAF at 1-800-652-6227 or by writing to JJPAF at PO Box 42796, Cincinnati, OH 45242, 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.
- This Authorization will last until I am no longer participating in the Program or sooner as limited by applicable state law.

***I know that I may refuse to sign this form*. My choice about whether to sign this form will not change the way healthcare 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 Patient Authorization to Elect Representative for Purposes of Program Enrollment *(if applicable)*

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

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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 Retail or specialty pharmacy. HCP must provide a prescription.	**Direct to HCP** Shipped to the HCP's office.	**Direct to Patient** Shipped to the patient's residence.
BALVERSA™ (erdafitinib)	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
EDURANT® (rilpivirine)	Tablets	☐	N/A	N/A
ELMIRON® (pentosan polysulfate sodium)	Capsules	☐	N/A	N/A
ERLEADA® (apalutamide)	Tablets	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 or ☐ Tablets	N/A	N/A	☐
INTELENCE® (etravirine)	Tablets	☐	N/A	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 HCl)	Tablets	☐	N/A	N/A
INVOKAMET® XR* (canagliflozin/metformin HCl)	Extended-release tablets	☐	N/A	N/A
INVOKANA®* (canagliflozin)	Tablets	☐	N/A	N/A
MONOVISC® (high molecular weight hyaluronan)	Injection	N/A	☐	N/A
ORTHOVISC® (high molecular weight hyaluronan)	Injection	N/A	☐	N/A
PREZCOBIX® (darunavir 800mg/cobicistat 150mg)	Tablets	☐	N/A	N/A
PREZISTA® (darunavir)	☐ Tablets or ☐ Oral Suspension	☐	N/A	N/A
PROCRIT®* (epoetin alfa) Required: Is the patient being treated on renal dialysis? ☐ Yes† ☐ No	Injection, for subcutaneous or intravenous use	☐	N/A	N/A
REMICADE®* (infliximab)	Intravenous Infusion	N/A	☐	N/A
RISPERDAL CONSTA®* (risperidone)	Long-acting injection	N/A	☐	N/A
SIMPONI®* (golimumab)	☐ SmartJect® or ☐ Prefilled syringe	☐	N/A	N/A
SIMPONI ARIA®* (golimumab)	Intravenous Infusion	N/A	☐	N/A
SIRTURO® (bedaquiline)	Tablets	☐	N/A	N/A
SPORANOX®* (itraconazole)	Capsules	☐	N/A	N/A
SPORANOX®* (itraconazole)	Oral solution	N/A	☐	N/A
SPRAVATO™* (esketamine) Nasal Spray CIII	Nasal Spray, for intranasal use	☐	N/A	N/A
STELARA® (ustekinumab)	☐ Injection, for subcutaneous use ☐ Injection, for intravenous use	☐	☐	N/A
SYMTUZA® (darunavir, cobicistat, emtricitabine, and tenofovir alafenamide)	Tablets	☐	N/A	N/A
TREMFYA® (guselkumab)	☐ Prefilled syringe ☐ One-Press patient-controlled injector	☐	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	☐

* See full U.S. prescribing information, including Black Box warning.
† Contact Amgen Inc. 1-800-772-6436.
Revised: June 2019

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TO BE COMPLETED BY THE HEALTHCARE PROFESSIONAL (HCP)

2 Prescription *(If requesting more than 1 product, attach additional prescription information.)*

Patient Name: _____ Date of Birth: _____

ICD Code *(HCP administered products only)*: _____ Name of product: _____

Strength: _____ Sig: _____

Quantity: _____ Days supply: _____ Number of Refills *(maximum 11)*: _____

If you are requesting BALVERSA™, ERLEADA®, IMBRUVICA®, or ZYTIGA® and you are a New York State Prescriber: Attach order for BALVERSA™, ERLEADA®, IMBRUVICA®, or ZYTIGA® on your NYS official prescription form.

If you are requesting BALVERSA™, ERLEADA®, IMBRUVICA®, or ZYTIGA®: List any patient allergies: _____ **or** ☐ NKDA

If you are requesting BALVERSA™, ERLEADA®, IMBRUVICA®, or ZYTIGA®: List patient's current medications: _____ **or** ☐ none

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

If you are requesting BALVERSA™: Has the patient tested positive for FGFR? ☐ **Yes** ☐ **No**

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

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

3 HCP Information

Name: _____ Site Name: _____ Site Contact: _____

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

Telephone: _____ Fax: _____ Email address: _____

Tax ID #: _____ National Provider ID # *(required)*: _____

State License # *(required)*: _____ Expiration *(mm/yyyy)*: _____ DEA # *(required)*: _____

Collaborating MD *(for mid-level providers)*: _____ Collaborating MD NPI # *(required)*: _____

Provider Transaction Access Number (PTAN) *(required if the patient has Medicare)* _____

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

Site Name: _____ 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.
- In accordance with the CMS Medicare Policy Manual, CMS will not reimburse you for any free product donated from JJPAF. In addition, in accordance with our eligibility criteria, Medicare Part B patients may receive free physician-administered product from JJPAF when such product is not covered by CMS. In such a case, and according to CMS policy, claims for administration services may not be reimbursed. You accept product from JJPAF with this understanding.
- 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.
- JJPAF reserves the right to request additional information if needed and to change or discontinue the Program at any time, without notice.

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.
- I authorize JJPAF or its affiliated companies or subcontractors to forward this prescription to a dispensing pharmacy by the above-named patient.
- I authorize JJPAF to use my provider information, including National Provider ID #, to determine patient program eligibility.
- That to the best of your knowledge this patient does not have prescription drug insurance coverage for the product(s) listed above.
- For SIRTURO®, if the patient has been diagnosed with pulmonary multi-drug resistant tuberculosis (MDR-TB), appropriate notification has been made to the local (state) health department.
- For SPRAVATO™*, the healthcare setting will be certified in the SPRAVATO™ Risk Evaluation and Mitigation Strategy (REMS) and the patient will be enrolled in the SPRAVATO™ REMS. SPRAVATO™ will not be dispensed directly to this patient for home use.
- For those patients that meet the JJPAF Medicare Part D eligibility criteria, your patient must submit a Medicare Part D certification letter.
- You are not prohibited from participating in Federally funded healthcare programs nor are you on the List of Excluded Individuals/Entities maintained by the HHS Office of Inspector General.
- That the medication(s) provided to you by the Program will not be provided or dispensed to any other person.

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

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

Revised: June 2019

Print Form