Stelara withMe | Stelara® (ustekinumab)

Patient Enrollment Form

UPDATE 05.24

Complete and fax this form to 866-769-3903. For assistance, prescribers can call 844-4withMe (844-494-8463), Monday–Friday, 8:00 AM–8:00 PM ET. A completed Patient Authorization Form, found on pages 5 and 6 of this document, is necessary to access certain patient support under STELARA withMe. Please submit the Patient Authorization Form with this completed Patient Enrollment Form.
The information you provide will be used by a pharmacy affiliated with Janssen Biotech, Inc., and its service providers (Pharmacy) in connection with your patient's treatment. The information you provide will be used in accordance with The Notice of Privacy Practices ("Privacy Policy").

Comprehensive support to help your patients start and stay on prescribed treatment

We will verify insurance coverage, support and monitor the prior authorization process, provide reimbursement information, help find affordability options for eligible patients, and provide ongoing support to help patients stay on STELARA®. This includes:

Delay and Denial Support: STELARA withMe offers eligible patients subcutaneous STELARA® at no cost until their commercial insurance covers the medication. To enroll your patient in Delay and Denial Support, a STELARA® Prescription via STELARA withMe must be completed in section 6.

Janssen Patient Assistance Program: Patient assistance is available if your patient has commercial, employer-sponsored, or government coverage that does not fully meet their needs. Your patient may be eligible to receive their Janssen medication free of charge for up to one year if they meet the eligibility and income requirements for the Janssen Patient Assistance Program. To enroll your patient in the Janssen Patient Assistance Program, a STELARA® Prescription via STELARA withMe is required in section 6.

▼ TO BE COMPLETED BY PATIENT AND PROVIDER ▼

1. Patient Information (REQUIRED)

FIRST NAME _____ LAST NAME _____ DOB (MM/DD/YYYY) _____ SEX ☐ M ☐ F

ADDRESS _____ CITY _____

STATE _____ ZIP CODE _____ PHONE _____ EMAIL _____

☐ The patient has consented to treatment by the Pharmacy and has authorized the collection, use, and disclosure of their health information as described in the Privacy Policy. I understand that the Pharmacy may be contacting the patient by phone or otherwise concerning this program.

2. Insurance Information (REQUIRED. Complete fields below OR provide a copy of insurance cards.)

MEDICAL INSURANCE (MI) _____ MI POLICY# _____ MI GROUP# _____

MI CARDHOLDER FIRST NAME _____ MI CARDHOLDER LAST NAME _____

MI DOB (MM/DD/YYYY) _____ RELATIONSHIP TO CARDHOLDER _____

PHARMACY INSURANCE (Rx) _____ Rx PCN# _____ Rx GROUP# _____

Rx CARDHOLDER FIRST NAME _____ Rx CARDHOLDER LAST NAME _____

Rx CARD/BIN# _____ Rx DOB (MM/DD/YYYY) _____

SECONDARY INSURANCE (SI) _____ SI POLICY# _____ SI GROUP# _____

SI CARDHOLDER FIRST NAME _____ SI CARDHOLDER LAST NAME _____ SI DOB (MM/DD/YY YY) _____

▼ TO BE COMPLETED BY PROVIDER ▼

3. Clinical Information (REQUIRED. The information requested is for benefits investigation purposes only.)

PRIMARY DIAGNOSIS:

PSORIASIS
- ☐ L40.0 (Psoriasis vulgaris)
- ☐ Other ICD-10 Code _____

PSORIATIC ARTHROPATHY
- ☐ L40.50 (Arthropathic psoriasis, unspecified)
- ☐ L40.51 (Distal interphalangeal psoriatic arthropathy)
- ☐ L40.52 (Psoriatic arthritis mutilans)
- ☐ L40.53 (Psoriatic spondylitis)
- ☐ L.40.54 (Psoriatic juvenile arthropathy)
- ☐ L40.59 (Other psoriatic arthropathy)
- ☐ Other ICD-10 Code _____

SECONDARY DIAGNOSIS: ICD-10 CODE _____

TB TEST DATE _____ DATE OF DIAGNOSIS OR YEARS WITH DISEASE _____

PATIENT WEIGHT _____ lb _____ kg % BSA AFFECTED _____

PRIOR MEDICATIONS (REQUIRED TO COMPLETE PRIOR AUTHORIZATION)

☐ Arava® ☐ Corticosteroids ☐ Cosentyx® ☐ Cyclosporine ☐ Enbrel® ☐ Humira® ☐ Methotrexate ☐ Otezla® ☐ Phototherapy
☐ Skyrizi® ☐ Soriatane® ☐ Taltz® ☐ Tremfya® ☐ Xeljanz® ☐ None ☐ Other _____

Please see the full Prescribing Information and Medication Guides for STELARA® and TREMFYA®.

4. Prescriber Information (REQUIRED)

PRESCRIBER FIRST NAME _____ PRESCRIBER LAST NAME _____

OFFICE CONTACT FIRST NAME _____ OFFICE CONTACT LAST NAME _____

PRACTICE NAME _____ PRACTICE TAX ID# _____ PRACTICE NPI# _____

OFFICE ADDRESS _____ OFFICE CITY _____

OFFICE STATE _____ OFFICE ZIP CODE _____ OFFICE PHONE _____ OFFICE FAX _____

5. Benefits Investigation (Required to complete benefits investigation. Do not prescribe these products together.)

I would like to request a benefits investigation for STELARA® (ustekinumab).

☐ 1 single-dose 45 mg prefilled syringe ☐ 1 single-dose 90 mg prefilled syringe
☐ 1 single-dose 45 mg vial ☐ 2 single-dose 45 mg vials

I would also like to request a benefits investigation for TREMFYA® (guselkumab) which is approved for adult patients only. (Pharmacy Insurance information must be provided.)

☐ 1 single-dose 100 mg One-Press patient-controlled injector ☐ 1 single-dose 100 mg prefilled syringe

SITE OF CARE ☐ Prescribing Physician's Office ☐ Non-prescribing Physician's Office ☐ Hospital Outpatient ☐ Other
(Required if different from prescriber)

PHYSICIAN FIRST NAME _____ PHYSICIAN LAST NAME _____

CONTACT FIRST NAME _____ CONTACT LAST NAME _____

SITE NAME _____ SITE PTAN# _____

SITE NPI# _____ SITE TAX ID# _____

SITE ADDRESS _____ SITE CITY _____

SITE STATE _____ SITE ZIP CODE _____ SITE PHONE _____ SITE FAX _____

6. Prescription Information (Required to complete benefits investigation.)

STELARA® Rx DIRECTIONS (Select all that apply.)

VIAL STARTER DOSE for plaque psoriasis and active psoriatic arthritis (ages 6-17) weighing less than 60 kg
☐ 1 single-dose 45 mg vial at ☐ Week 0 ☐ Week 4

PREFILLED SYRINGE STARTER DOSE
☐ 1 single-dose 45 mg SC prefilled syringe ☐ Week 0 ☐ Week 4
☐ 1 single-dose 90 mg SC prefilled syringe ☐ Week 0 ☐ Week 4

VIAL MAINTENANCE THERAPY for plaque psoriasis and active psoriatic arthritis (ages 6-17) weighing less than 60 kg
☐ 1 single-dose 45 mg vial every 12 weeks Refills #_____

PREFILLED SYRINGE MAINTENANCE THERAPY
☐ 1 single-dose 45 mg SC prefilled syringe every 12 weeks Refills #_____
☐ 1 single-dose 90 mg SC prefilled syringe every 12 weeks Refills #_____

STELARA® Prescription

Signature required to enroll eligible patients in Delay and Denial Support or Janssen Patient Assistance Program.

PRESCRIBER SIGNATURE (Dispense as written) _____ DATE _____

By submitting this prescription, I understand the Pharmacy will check the patient's eligibility for and may enroll the patient in certain support programs based on the results of the benefits investigation with patient consent. If the patient is eligible for support programs, I certify that I agree to the programs' requirements and will take the necessary actions described in the requirements for the patient. See program requirements on page 4.

Commercial Pharmacy Prescription (OPTIONAL)

Patient or provider preferred pharmacy _____

PRESCRIBER SIGNATURE (Dispense as written) _____ DATE _____

PRESCRIBER SIGNATURE (NO STAMPS ALLOWED) REQUIRED TO VALIDATE PRESCRIPTION: I certify that therapy with STELARA® is medically necessary for this patient. I will be supervising the patient's treatment accordingly, and I have reviewed the current STELARA® Prescribing Information.

INDICATIONS

STELARA® (ustekinumab) is indicated for the treatment of patients 6 years and older with active psoriatic arthritis.

STELARA® (ustekinumab) is indicated for the treatment of patients 6 years or older with moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy.

STELARA® (ustekinumab) is indicated for the treatment of adult patients with moderately to severely active Crohn's disease.

STELARA® (ustekinumab) is indicated for the treatment of adult patients with moderately to severely active ulcerative colitis.

IMPORTANT SAFETY INFORMATION

STELARA® (ustekinumab) is contraindicated in patients with clinically significant hypersensitivity to ustekinumab or to any of the excipients.

Infections

STELARA® may increase the risk of infections and reactivation of latent infections. Serious bacterial, mycobacterial, fungal, and viral infections requiring hospitalization or otherwise clinically significant infections were reported. In patients with plaque psoriasis, these included diverticulitis, cellulitis, pneumonia, appendicitis, cholecystitis, sepsis, osteomyelitis, viral infections, gastroenteritis, and urinary tract infections. In patients with psoriatic arthritis, this included cholecystitis. In patients with Crohn's disease, these included anal abscess, gastroenteritis, ophthalmic herpes zoster, pneumonia, and *Listeria* meningitis. In patients with ulcerative colitis, these included gastroenteritis, ophthalmic herpes zoster, pneumonia, and listeriosis.

Treatment with STELARA® should not be initiated in patients with a clinically important active infection until the infection resolves or is adequately treated. Consider the risks and benefits of treatment prior to initiating use of STELARA® in patients with a chronic infection or a history of recurrent infection. Instruct patients to seek medical advice if signs or symptoms suggestive of an infection occur while on treatment with STELARA® and discontinue STELARA® for serious or clinically significant infections until the infection resolves or is adequately treated.

Theoretical Risk for Vulnerability to Particular Infections

Individuals genetically deficient in IL-12/IL-23 are particularly vulnerable to disseminated infections from mycobacteria, *Salmonella*, and *Bacillus Calmette-Guerin* (BCG) vaccinations. Serious infections and fatal outcomes have been reported in such patients. It is not known whether patients with pharmacologic blockade of IL-12/IL-23 from treatment with STELARA® may be susceptible to these types of infections. Consider diagnostic testing, eg, tissue culture, stool culture, as dictated by clinical circumstances.

Pre-Treatment Evaluation of Tuberculosis (TB)

Evaluate patients for TB prior to initiating treatment with STELARA®. Do not administer STELARA® to patients with active tuberculosis infection. Initiate treatment of latent TB before administering STELARA®. Closely monitor patients receiving STELARA® for signs and symptoms of active TB during and after treatment.

Malignancies

STELARA® is an immunosuppressant and may increase the risk of malignancy. Malignancies were reported among patients who received STELARA® in clinical trials. The safety of STELARA® has not been evaluated in patients who have a history of malignancy or who have a known malignancy. There have been reports of the rapid appearance of multiple cutaneous squamous cell carcinomas in patients receiving STELARA® who had risk factors for developing non-melanoma skin cancer (NMSC). All patients receiving STELARA®, especially those >60 years or those with a history of PUVA or prolonged immunosuppressant treatment, should be monitored for the appearance of NMSC.

Hypersensitivity Reactions

Hypersensitivity reactions, including anaphylaxis and angioedema, have been reported with STELARA®. If an anaphylactic or other clinically significant hypersensitivity reaction occurs, institute appropriate therapy and discontinue STELARA®.

Posterior Reversible Encephalopathy Syndrome (PRES)

Two cases of posterior reversible encephalopathy syndrome (PRES), also known as Reversible Posterior Leukoencephalopathy Syndrome (RPLS), were reported in clinical trials. Cases have also been reported in postmarketing experience in patients with psoriasis, psoriatic arthritis and Crohn's disease. Clinical presentation included headaches, seizures, confusion, visual disturbances, and imaging changes consistent with PRES a few days to several months after ustekinumab initiation. A few cases reported latency of a year or longer. Patients recovered with supportive care following withdrawal of ustekinumab.

Monitor all patients treated with STELARA® for signs and symptoms of PRES. If PRES is suspected, promptly administer appropriate treatment and discontinue STELARA®.

Immunizations

Prior to initiating therapy with STELARA®, patients should receive all age-appropriate immunizations as recommended by current immunization guidelines. Patients being treated with STELARA® should avoid receiving live vaccines. Avoid administering BCG vaccines during treatment with STELARA® or for one year prior to initiating treatment or one year following discontinuation of treatment. Caution is advised when administering live vaccines to household contacts of patients receiving STELARA® because of the potential risk for shedding from the household contact and transmission to patient. Non-live vaccinations received during a course of STELARA® may not elicit an immune response sufficient to prevent disease.

Noninfectious Pneumonia

Cases of interstitial pneumonia, eosinophilic pneumonia, and cryptogenic organizing pneumonia have been reported during post-approval use of STELARA®. Clinical presentations included cough, dyspnea, and interstitial infiltrates following one to three doses. Serious outcomes have included respiratory failure and prolonged hospitalization. Patients improved with discontinuation of therapy and, in certain cases, administration of corticosteroids. If diagnosis is confirmed, discontinue STELARA® and institute appropriate treatment.

Allergen Immunotherapy

STELARA® may decrease the protective effect of allergen immunotherapy (decrease tolerance) which may increase the risk of an allergic reaction to a dose of allergen immunotherapy. Therefore, caution should be exercised in patients receiving or who have received allergen immunotherapy, particularly for anaphylaxis.

Most Common Adverse Reactions

The most common adverse reactions (≥3% and higher than that with placebo) in adults from plaque psoriasis clinical trials for STELARA® 45 mg, STELARA® 90 mg, or placebo were: nasopharyngitis (8%, 7%, 8%), upper respiratory tract infection (5%, 4%, 5%), headache (5%, 5%, 3%), and fatigue (3%, 3%, 2%), respectively. The safety profile in pediatric patients with plaque psoriasis was similar to that of adults with plaque psoriasis. In psoriatic arthritis (PsA) trials, a higher incidence of arthralgia and nausea was observed in patients treated with STELARA® when compared with placebo (3% vs 1% for both). In Crohn's disease induction trials, common adverse reactions (3% or more of patients treated with STELARA® and higher than placebo) reported through Week 8 for STELARA® 6 mg/kg intravenous single infusion or placebo included: vomiting (4% vs 3%). In the Crohn's disease maintenance trial, common adverse reactions (3% or more of patients treated with STELARA® and higher than placebo) reported through Week 44 for STELARA® 90 mg subcutaneous injection or placebo were: nasopharyngitis (11% vs 8%), injection site erythema (5% vs 0%), vulvovaginal candidiasis/mycotic infection (5% vs 1%), bronchitis (5% vs 3%), pruritus (4% vs 2%), urinary tract infection (4% vs 2%) and sinusitis (3% vs 2%). In the ulcerative colitis induction trial, common adverse reactions (3% or more of patients treated with STELARA® and higher than placebo) reported through Week 8 for STELARA® 6 mg/kg intravenous single infusion or placebo included: nasopharyngitis (7% vs 4%). In the ulcerative colitis maintenance trial, common adverse reactions (3% or more of patients treated with STELARA® and higher than placebo) reported through Week 44 for STELARA® 90 mg subcutaneous injection or placebo included: nasopharyngitis (24% vs 20%), headache (10% vs 4%), abdominal pain (7% vs 3%), influenza (6% vs 5%), fever (5% vs 4%), diarrhea (4% vs 1%), sinusitis (4% vs 1%), fatigue (4% vs 2%), and nausea (3% vs 2%).

cp-124933v7

Please see the full Prescribing Information and Medication Guides for STELARA® and TREMFYA®.

  05/24 cp-414764v2

INDICATIONS

TREMFYA® (guselkumab) is indicated for the treatment of adults with moderate to severe plaque psoriasis who are candidates for systemic therapy or phototherapy.

TREMFYA® is indicated for the treatment of adults with active psoriatic arthritis.

IMPORTANT SAFETY INFORMATION

CONTRAINDICATIONS

TREMFYA® is contraindicated in patients with a history of serious hypersensitivity reaction to guselkumab or to any of the excipients.

WARNINGS AND PRECAUTIONS

Hypersensitivity Reactions

Serious hypersensitivity reactions, including anaphylaxis, have been reported with postmarket use of TREMFYA®. Some cases required hospitalization. If a serious hypersensitivity reaction occurs, discontinue TREMFYA® and initiate appropriate therapy.

Infections

TREMFYA® may increase the risk of infection. Treatment with TREMFYA® should not be initiated in patients with a clinically important active infection until the infection resolves or is adequately treated.

Consider the risks and benefits of treatment prior to prescribing TREMFYA® in patients with a chronic infection or a history of recurrent infection. Instruct patients receiving TREMFYA® to seek medical help if signs or symptoms of clinically important chronic or acute infection occur. If a patient develops a clinically important or serious infection, or is not responding to standard therapy, closely monitor and discontinue TREMFYA® until the infection resolves.

Pre-Treatment Evaluation for Tuberculosis (TB)

Evaluate patients for TB infection prior to initiating treatment with TREMFYA®. Initiate treatment of latent TB prior to administering TREMFYA®. Monitor patients for signs and symptoms of active TB during and after TREMFYA® treatment. Do not administer TREMFYA® to patients with active TB infection.

Immunizations

Prior to initiating TREMFYA®, consider completion of all age-appropriate immunizations according to current immunization guidelines. Avoid use of live vaccines in patients treated with TREMFYA®.

ADVERSE REACTIONS

Most common (≥1%) adverse reactions associated with TREMFYA® include upper respiratory infections, headache, injection site reactions, arthralgia, bronchitis, diarrhea, gastroenteritis, tinea infections, and herpes simplex infections.

The overall safety profile observed in patients with psoriatic arthritis is generally consistent with the safety profile in patients with plaque psoriasis, with the addition of bronchitis and neutrophil count decreased.

cp-82625v3

Please see the full Prescribing Information and Medication Guides for STELARA® and TREMFYA®.

  05/24 cp-414764v2

Information about your patient's insurance coverage, cost support options, and treatment support is given by service providers for STELARA withMe and TREMFYA withMe via 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, STELARA withMe and TREMFYA withMe cannot promise the information will be complete. STELARA withMe and TREMFYA withMe cost support are not for patients in the Johnson & Johnson Patient Assistance Foundation.

The patient support and resources provided by STELARA withMe and TREMFYA withMe are 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.

STELARA withMe Delay and Denial Support

STELARA withMe offers eligible patients subcutaneous STELARA® (ustekinumab) **at no cost** until their commercial insurance covers the medication. See program requirements below.

To be eligible, patient must have:

1. a subcutaneous STELARA® prescription for an on-label, FDA-approved indication
2. commercial insurance with biologics coverage
3. a delay of more than 5 business days or a denial of treatment from their insurance.

In addition, for patient to be eligible, Prescriber must submit:

4. a coverage determination form (ie, prior authorization or prior authorization with exception) to the commercial insurance.

If coverage is denied, Prescriber must also submit a Letter of Formulary Exception, Letter of Medical Necessity, or appeal within 90 days of patient becoming eligible for patient to stay in the program.

Patient is not eligible if:

1. patient uses any state or federal government-funded healthcare program to cover medication costs. Examples of these programs are Medicare, Medicaid, TRICARE, Department of Defense, and Veterans Administration
2. prior authorization is denied due to missing information on coverage determination form, use for a non-FDA-approved indication, or invalid clinical rationale.

Patient is eligible until commercial insurance covers the medication. Program requires periodic verification of insurance coverage status to confirm continued eligibility.

Program covers the cost of therapy only—not associated administration cost. Prescriber cannot bill commercial insurance plan for any part of the prescribed subcutaneous treatment. Patient cannot submit the value of the free product as a claim for payment to any health plan. Program good only in the United States and its territories. Void where prohibited, taxed, or limited by law. Program terms may change.

JANSSEN PATIENT ASSISTANCE PROGRAM

Your patient may be eligible to receive their Janssen medication(s) free of charge for up to one year if they have been prescribed a Janssen medication, have a financial hardship, and are currently enrolled in government, commercial, or employer group health insurance.

Your patient must meet the eligibility and income requirements to qualify for the patient assistance program.

Your patient is not eligible for free Janssen medication if their health insurance will cover the cost of their Janssen-prescribed medication if this application is denied. Some employers, insurers, and other companies force patients to apply for medically necessary medications from free product programs instead of covering such medications directly and immediately through insurance, which could lead to delays in care and discriminate against lower-income patients. These types of "Assistance Diversion Programs" are generally established by companies that profit by diverting resources away from patients in need. An Assistance Diversion Program is any insurer, employer, or third-party program that withholds coverage or payment for Patient's medically necessary drug until Patient has completed an application for free product assistance. Assistance Diversion Programs are prohibited by Janssen to make sure that help is available for patients with no safety net in place. Your patient's insurer must submit a Patient Eligibility Certification form to confirm that their drug coverage is not subject to an Assistance Diversion Program.

Your patient may not seek payment for the value of Janssen medications received from this program from any health plan, patient assistance foundation, flexible spending account, or healthcare savings account.

Before your patient enrolls in the patient assistance program, it is important they understand that they will be asked to provide personal information that may include their name, address, phone number, email address, financial information, and information related to their prescription medication insurance and treatment. This information will be used by Janssen Biotech, Inc., and its service providers to determine their eligibility for, enroll them in, and administer the program. The information will also be used to learn more about the people who use the program, to improve the program, and will be shared with service providers supporting the program.

If your patient has Medicare Prescription Drug Coverage (Part D) they may be asked to attest to or submit a report from their pharmacy or an Explanation of Benefits (EOB) statement from their insurer that shows their out-of-pocket costs for the current year. To qualify for the program, 4% of the patient's gross annual household income must be spent on out-of-pocket prescription expenses for the patient and/or other members of their household.

This program offer may not be used with any other coupon, discount, prescription savings card, free trial, or other offer. Offer good only in the United States and its territories. Void where prohibited, taxed, or limited by law. Program terms will expire at the end of each calendar year and may change or end without notice, including in specific states.

Your patient may end their participation in the program at any time by calling 844-4withMe (844-494-8463), Monday through Friday, 8:00 AM to 8:00 PM ET.

Please see the full Prescribing Information and Medication Guides for STELARA® and TREMFYA®.

  05/24 cp-414764v2

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 866-769-3903 or mailed to STELARA withMe, PO Box 15510, Pittsburgh, PA 15244**

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 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.

Janssen Patient Support Program Patient Authorization Form

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: STELARA withMe, PO Box 15510, Pittsburgh, PA 15244.

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:

_____

