Patient Enrollment Form Cover Sheet

FAX: 877-785-1124 Questions? Call us: 877-524-3579, Monday–Friday, 8:00 AM–8:00 PM ET

Date ____________________ **Pages** ____________________

Subject: **Janssen CarePath Patient Enrollment**

From ____________________

Fax # ____________________

Help empower your patient to start and stay on your prescribed treatment plan.

To enroll your patient:

1. Complete the **required** pages of the Patient Enrollment Form as noted below:

Page 1 of 6—REQUIRED: Healthcare Professional Information, Prescription, and Patient Insurance Information.
Please ensure there is a Healthcare Professional signature in the Prescription section.

Page 3 of 6—REQUIRED: Program Offerings, HIPAA Authorization for Janssen CarePath, and optional HIPAA Authorizations.
Please ensure there is a Patient Signature or "person legally authorized to sign" signature in the Patient Authorization section.

2. Fax pages 1 of 6 and 3 of 6 to Janssen CarePath: 877-785-1124

Upon receipt of your completed Patient Enrollment Form:

- A Fax Confirmation will be sent to your office
- We will begin working on your selected Program Offerings
- We will contact you with next steps

Need help? Call **877-524-3579**
Monday–Friday, 8:00 AM–8:00 PM ET

Please see full Prescribing Information, including Boxed WARNING, for INVEGA SUSTENNA®, INVEGA TRINZA®, and RISPERDAL CONSTA®, available at janssen.com/us/our-products.

© Janssen Pharmaceuticals, Inc. 2018
April 2018 cp-51040v1

Patient Enrollment Form

UPDATE 2.18

FAX: 877-785-1124 Questions? Call us: 877-524-3579, Monday–Friday, 8:00 AM–8:00 PM ET

Healthcare Professional (HCP)

HCP Name ______

Facility Name ______

Address ______

City ______ State ____ ZIP ______

Phone ______ Fax ______ NPI # ______

Facility Contact(s)* ______

Phone ______

Facility Type: Inpatient/Hospital Outpatient Clinic/ Private Practice Correctional Telepsychiatry

*By including a facility contact name other than the HCP, the HCP is authorizing the facility contact to accurately relay HCP directions to Janssen CarePath. The HCP will provide appropriate oversight to ensure orders are accurately relayed and that the HCP is informed about all program information relevant to the clinical care of the patient.

Prescription

CHECK HERE IF A COPY OF THE PRESCRIPTION IS ATTACHED AND SIGN TO RIGHT.

Patient Name ______ Sex M F

Patient Address ______

City ______ State ____ ZIP ______

Phone ______ DOB (MM/DD/YYYY) ____/____/______

Is patient new to this medication? Yes No

Diagnosis/ICD Code ______

Preferred Language: English Spanish Other______

Please list any known drug allergies ______

INVEGA SUSTENNA® (paliperidone palmitate)
39 mg, 78 mg, 117 mg, 156 mg, 234 mg

Day 1 Dose ____mg IM Injection Date ____/____/______

Day 8 Dose ____mg IM Injection Date ____/____/______

Maintenance Dose ____mg IM every 4 weeks

Injection Date ____/____/______ (+/−7 days of scheduled dose)

Refills ______ Directions______

INVEGA TRINZA® (paliperidone palmitate)
273 mg, 410 mg, 546 mg, 819 mg

Dose ______mg IM every 3 months

Injection Date ____/____/______
(+/−14 days of scheduled dose, with the exception of first dose)

Refills ______ Directions ______

RISPERDAL CONSTA® (risperidone) 12.5 mg, 25 mg, 37.5 mg, 50 mg

Dose ______mg IM every 2 weeks

QTY ______ Date Needed ____/____/______

Refills ______ Directions ______

Prescription (continued)

I certify that the above medication is medically necessary and that the information provided is accurate to the best of my knowledge. By my signature, I also acknowledge that I have obtained the patient's authorization to release the above information and such other information as may be required by Janssen CarePath to provide the offerings selected. I appoint Janssen CarePath, on my behalf, to convey this prescription to the dispensing pharmacy of the patient's choice. I further certify that (a) any offering provided through Janssen CarePath on behalf of any patient is not made in exchange for any express or implied agreement or understanding that I would recommend, prescribe, or use Janssen CarePath or any other product or service for anyone, and that (b) my decision to prescribe the products set forth on this page and request Janssen CarePath offerings for my patient was based solely on my determination of medical necessity as set forth herein, and that (c) I will not seek reimbursement for any offering provided by or through Janssen CarePath from any government program or third-party insurer.

X ______ ____/____/____
Dispense as written Date

X ______ ____/____/____
Substitution accepted Date

X ______ ____/____/____
Supervising Physician Signature (if applicable) Date

______
Supervising Physician Name (print name)

THIS PRESCRIPTION IS ONLY VALID IF RECEIVED BY FAX, MEETING STATE REGULATIONS

Insurance

CHECK HERE IF YOU ARE ATTACHING A COPY OF THE INSURANCE CARDS.

Primary Insurance Name ______

Phone ______

Cardholder Name ______

Policy # ______ Group # ______

If patient has a separate prescription coverage plan, please list below.

Prescription Plan Name ______

Phone ______

Policy # ______ Group # ______

BIN # ______ PCN # ______

Instant Savings Card

Please provide an Instant Savings Card for my patient. To the best of my knowledge, patient has commercial insurance that covers medication costs and is not enrolled in federal or state subsidized healthcare programs that cover prescription drugs, including Medicare, Medicaid, TRICARE, or any other federal or state healthcare plan, including pharmaceutical assistance programs. We understand and agree that a benefit verification will be performed and an Instant Savings Card will not be provided if eligibility cannot be verified.

My patient requests that associated Instant Savings Card information be provided to pharmacy along with their insurance information if appropriate.

Reset Print Page

Please see full Prescribing Information, including Boxed WARNING, for INVEGA SUSTENNA®, INVEGA TRINZA®, and RISPERDAL CONSTA®, available at janssen.com/us/our-products.

© Janssen Pharmaceuticals, Inc. 2018

The information you provide will be used by Janssen Pharmaceuticals, Inc., our affiliates, and our program administrators for the registration, fulfillment, and administration of the Janssen CarePath program, and to fulfill other requests you may select. Janssen Pharmaceuticals, Inc., may also send you information about products and programs that may be of interest to you. You may withdraw from receiving these communications by calling 877-524-3579. Our Privacy Policy, available at janssen.com/us/privacy-policy, governs the use of the information you provide. By providing and submitting the information, you indicate that you read, understand, and agree to these terms.

Disclaimer:

Information and assistance (eg, information regarding access and reimbursement, the inpatient/outpatient appointment gap, medication shipment, additional alternate site of care options, and follow-through of healthcare professional–directed treatment plan) are provided by third-party Program Administrators for Janssen CarePath ("Program Administrator"), under contract with Janssen Pharmaceuticals, Inc. ("JPI").

This Patient Enrollment Form, with sections completed for requested information regarding assistance, must be submitted to Program Administrator by the healthcare professional ("HCP") in order to activate any Janssen CarePath assistance. No other forms for request for access to Janssen CarePath will be accepted. Assistance cannot be directly requested by the patient. Janssen CarePath is not available to patients participating in the Patient Assistance Program offered by Johnson & Johnson Patient Assistance Foundation. The availability of information and assistance may vary based on geography.

Program Administrator provides information to HCPs regarding whether the treatment is covered by the applicable third-party payer, based on the payer's coverage guidelines and the patient information provided by the HCP. This information and assistance are made available as a convenience to patients, and there is no requirement that patients or HCPs use any JPI or other Johnson & Johnson product in exchange for this information or assistance.

Third-party reimbursement is affected by many factors. This document and the information and assistance provided by Janssen CarePath are presented for informational purposes only. They do not constitute reimbursement or legal advice. Janssen CarePath does not promise or guarantee coverage, levels of reimbursement, or payment.

Similarly, all CPT®* and HCPCS* codes are supplied for informational purposes only and represent no statement, promise, or guarantee expressed or implied by JPI or Program Administrator that these codes will be appropriate or that reimbursement will be made. The fact that a drug, device, procedure, or service is assigned an HCPCS code and a payment rate does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the Medicare program.

Laws, regulations, and policies concerning reimbursement are complex and are updated frequently. Accordingly, the information may not be current or comprehensive. JPI and Program Administrator strongly recommend you consult your payer for its most current coverage, reimbursement, and coding policies. Program Administrator and JPI make no representations or warranties, expressed or implied, as to the accuracy of the information provided. In no event shall Program Administrator or JPI, or their employees or agents, be liable for any damages resulting from or relating to any information provided by or access to or through Janssen CarePath. All HCPs and other users of this information agree that they accept responsibility for the use of this program.

JPI assumes no responsibility for and does not guarantee the quality, scope, or availability of the information and assistance provided (eg, information regarding access and reimbursement, the inpatient/outpatient appointment gap, medication shipment, additional alternate site of care options, and follow-through of HCP-directed treatment plan). Program Administrator, not JPI, is responsible for the information and assistance it provides under this program. Each HCP and patient is responsible for verifying or confirming any information provided by Program Administrator or JPI. All claims and other submissions to payers should be in compliance with all applicable requirements.

Analytics (eg, data points or statistics about the program), if provided, are as of the date noted and may not be representative of future analytics or your patients or practice. Please consider appropriate use of Janssen CarePath information and assistance in light of your practice and individual patients' clinical needs and applicable payer requirements.

Please see full Prescribing Information, including Boxed WARNING, for INVEGA SUSTENNA®, INVEGA TRINZA®, and RISPERDAL CONSTA®, available at janssen.com/us/our-products.

*CPT = Current Procedural Terminology; HCPCS = Healthcare Common Procedure Coding System.

CPT® codes and descriptions are copyright 2017 American Medical Association. All rights reserved.
CPT® is a registered trademark of the American Medical Association.

© Janssen Pharmaceuticals, Inc. 2018

Patient Enrollment Form

UPDATE 2.18

FAX: 877-785-1124 Questions? Call us: 877-524-3579, Monday–Friday, 8:00 AM–8:00 PM ET

Alternate Patient Contact (optional)

This contact information will be used to coordinate care services if the patient cannot be reached or is unable to manage his/her care. See full Patient Authorization for Janssen CarePath on page 4 of this enrollment packet for a full description of what may be discussed with the alternate contact listed below.

Name ______________________________

Relationship to Patient ______________________________

Phone ______________________________

Program Offerings

CHECK THE BOX NEXT TO EACH OFFERING YOU WOULD LIKE FOR YOUR PATIENT.

Benefit Verification

(By completing this section, you are also requesting a benefit investigation)

Prior Authorization Form Assistance: By checking this, I request that Janssen CarePath assist my office in addressing the requirements of this patient's health plan related to prior authorization for treatment with INVEGA SUSTENNA® (paliperidone palmitate), INVEGA TRINZA® (paliperidone palmitate) and/or RISPERDAL CONSTA® (risperidone). I understand that assistance may include obtaining the health-plan–specific prior authorization form and completing 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 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.

Care Transition Support

Provide Information and Assistance to Help My Patient Transition to the Next Healthcare Setting.

Facility and/or HCP Name ______________________________

Phone ______________ Contact(s) ______________

Address ______________________________

City ______________ State ____ ZIP ______

Reminder Alert: Provide a Reminder Alert for Patient's **Initial Office Visit** at Next Site of Care, Scheduled on Date ____/____/______ Time_____

Schedule Patient's **Initial Office Visit** With Next Site of Care, and Include a Reminder Alert.

Reminder Alerts Only

Please Provide Reminder Alerts for My Patient Who Will Be Receiving Injections in My Office.

My Patient's Next Injection at My Office Is Scheduled for Date ____/____/______

Program Offerings (continued)

CHECK THE BOX NEXT TO EACH OFFERING YOU WOULD LIKE FOR YOUR PATIENT.

Medication Shipment*

Provide Assistance in Coordinating My Patient's Medication Shipment to My Office.

Ship to HCP's Secondary Location at ______________________________

City ______________ State ____ ZIP ______

* By selecting Medication Shipment, I understand that Prior Authorization Status Monitoring will also be provided, if applicable.

Alternate Site of Care Options for Injection

(if available in your geography)

By selecting Alternate Site of Care Options for Injection, I understand that Prior Authorization Status Monitoring will also be provided, if applicable.

Fax Me a List of Available Locations.

Contact My Patient to Select a Location.
If my patient does not select a location within 48 hours of being contacted by Janssen CarePath, I am ordering that the location closest to my patient be selected.

Select a Location Closest to My Patient.

Use the Following Approved JANSSEN CONNECT® Network Location:

____

By naming the above location, I attest that I do not have a financial relationship with the alternate site of care listed.

Patient Authorization

My signature below certifies that I have read, understand, and agree to the Patient Authorization to release my protected health information to Janssen CarePath, my health plan or other third-party payers, and third parties that assist Janssen CarePath with the provision of patient offerings for Janssen CarePath, as defined on page 4 in the "Patient Copy."

PATIENT SIGNATURE ______________________________

Date ____/____/______

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

Patient Name ______________________________

By ______________________________

Signature of person legally authorized to sign for patient/relationship

My signature above also certifies that I have read, understand, and agree to the Patient Authorization(s) on pages 5 and 6 of the Patient Copy **that I have checked below** to release my protected health information:

Optional HIPAA Authorization for the following:

Marketing Activities—see page 5

Sharing Janssen CarePath Patient Data With Payer—see page 6

Reset | Print Page

Please see full Prescribing Information, including Boxed WARNING, for INVEGA SUSTENNA®, INVEGA TRINZA®, and RISPERDAL CONSTA®, available at janssen.com/us/our-products.

© Janssen Pharmaceuticals, Inc. 2018

Patient Copy

Provider Instructions

1. **Have the patient read this form and sign the acknowledgement on page 3 of the Patient Enrollment Form relating to the Patient Authorization.**
2. **Provide the patient with this sheet and a copy of page 3 of the Patient Enrollment Form, which they have signed.**
3. **Have the patient read pages 5 and 6 if they wish to provide one or both of the Optional HIPAA Authorizations.**

HIPAA Authorization for Janssen CarePath:

I hereby authorize the use and/or disclosure of my private health information, described below, which includes "Protected Health Information" as defined in federal laws called the Privacy Regulations developed under the Health Insurance Portability and Accountability Act of 1996 (as amended, "HIPAA"). In general terms, I understand that Protected Health Information is health information that identifies me or that could be used to identify me. I understand that this authorization is voluntary.

The following person(s) or class of persons are authorized to disclose this information:

1. Physicians or other healthcare providers who have provided treatment or services to me. I understand that pharmacies that ship my medication may be paid to share this information with Janssen CarePath to help provide the offerings requested for me.
2. The company administering Janssen CarePath, which is a third-party Program Administrator under contract with Janssen Pharmaceuticals, Inc. (referred to herein as "Program Administrator").
3. My health plan or other third-party payer.
4. Physicians and other healthcare providers as directed by the healthcare professional enrolling me in Janssen CarePath.

The following person(s) or class of persons are authorized to receive the information:

1. Janssen CarePath.
2. My health plan or other third-party payer.
3. Third parties that assist Program Administrator with the provision of patient offerings for Janssen CarePath.

Description of the information that may be used and/or disclosed:

My diagnosis, prescribed therapy (eg, INVEGA SUSTENNA® [paliperidone palmitate], INVEGA TRINZA® [paliperidone palmitate], or RISPERDAL CONSTA® [risperidone]), and a description of the patient offerings I have requested or received from Janssen CarePath. I understand that the information disclosed about me may include mental health information and/or records.

The information will be used and/or disclosed for the following purpose(s):

1. For the provision of the Janssen CarePath patient offerings requested, such as investigating my prescribed therapy coverage status, assisting with understanding prior authorization or appeal requirements, providing information and assistance to help my transition to my next healthcare setting, assisting in coordinating my medication shipment, helping me determine additional injection center options, and providing welcome and reminder alerts.
2. In response to a court order, subpoena, or otherwise required by law.

Redisclosure: I understand that the Protected Health Information disclosed pursuant to this authorization may be redisclosed by Program Administrator, for the purposes outlined above—to my health plan(s) or other third-party payer(s), my healthcare providers, Janssen CarePath contractors, and any individual I designate as an alternate contact—and I specifically authorize such redisclosures.

Rights and other terms:

1. Inability to Condition Treatment, Payment, Enrollment, or Eligibility for Benefits on Provision of Authorization. I understand that my healthcare providers and health plan(s) may not condition my treatment, payment, eligibility for benefits, or enrollment in the health plan upon my signing this authorization.
2. Copy of Authorization. I understand that I am entitled to a signed copy of this authorization.
3. Expiration of Authorization. I understand that this authorization shall expire either when I stop receiving Janssen CarePath patient offerings or 10 years from the date of this authorization, whichever occurs first.
4. Right to Revoke Authorization. I understand that I may revoke (ie, take back) this authorization at any time except to the extent the recipients of my information have already taken action in reliance on my authorization. To revoke, I understand that I must notify Janssen CarePath in writing at the following toll-free fax number: 877-785-1124.
5. HIPAA. I understand that the persons who receive my health information pursuant to this authorization may not be required by federal law (such as HIPAA) to protect it and may share my information with others if permitted by applicable law.
6. Review Information Disclosed. I understand that I have the right to review the information that has been disclosed pursuant to this authorization upon written request to Janssen CarePath at the following toll-free fax number: 877-785-1124.

You are encouraged to report side effects of prescription drugs to the FDA. Visit www.fda.gov/safety/medwatch, or call 800-FDA-1088.

Please see full Prescribing Information, including Boxed WARNING, for INVEGA SUSTENNA®, INVEGA TRINZA®, and RISPERDAL CONSTA®, available at janssen.com/us/our-products.

© Janssen Pharmaceuticals, Inc. 2018

Patient Copy

Provider Instructions

1. **Have the patient read this form and check the box on page 3 of the Patient Enrollment Form if they wish to provide this Optional HIPAA Authorization.**
2. **Provide the patient with this sheet and a copy of page 3 of the Patient Enrollment Form, which they have signed.**

HIPAA Authorization for Marketing Activities:

I have enrolled in the Janssen CarePath program and have authorized certain health information about me to be disclosed to the company that administers Janssen CarePath, which is a third-party program administrator under contract with Janssen Pharmaceuticals, Inc. (referred to herein as "Program Administrator"). This health information ("Personal Information") includes information about the following:

- My diagnosis.
- The therapy prescribed to me (eg, INVEGA SUSTENNA® [paliperidone palmitate], INVEGA TRINZA® [paliperidone palmitate], or RISPERDAL CONSTA® [risperidone]).
- The patient offerings I have received from Janssen CarePath.

This Personal Information may reveal mental-health–related information about me. I now hereby authorize Program Administrator to use my Personal Information to:

- Send me educational and marketing materials regarding the Janssen CarePath program, my prescribed therapy, and other related products or offerings in which I might be interested.
- Contact me to obtain feedback about Janssen Pharmaceuticals, Inc., the administrator of the program, the Janssen CarePath program, and my prescribed therapy.
- Manage and improve the Janssen CarePath program.
- Respond to a court order, subpoena, or as otherwise required by law.

This information and contact may occur by phone, text, email, or postal mail unless I request otherwise from Janssen CarePath. I understand that Janssen CarePath will only share my Personal Information with third parties that provide support for Janssen CarePath pursuant to contracts where those third parties agree to use the information only as described in this authorization, or as required by law or legal process.

I understand that, with respect to this authorization:

- I sign this authorization voluntarily. I understand that I may refuse to sign this authorization.
- I understand that Program Administrator will receive payment from Janssen Pharmaceuticals, Inc., for providing me with the information and materials described in this authorization.
- I am entitled to a signed copy of this authorization for my records.
- I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance upon this authorization, and if not earlier revoked, this authorization will terminate on the sooner of (i) when I stop receiving Janssen CarePath patient offerings, or (ii) 10 years from the date of this authorization. To revoke, I understand that I must notify Janssen CarePath in writing at the following toll-free fax number: 877-785-1124. I understand that any revocation will not apply to information that has already been used and released in response to this authorization.
- The persons who receive my health information pursuant to this authorization may not be required by federal law (such as HIPAA) to protect it and may share my information with others if permitted by applicable law.
- I understand that I have the right to review any information that has been disclosed pursuant to this authorization upon written request to Janssen CarePath at the following toll-free fax number: 877-785-1124.

You are encouraged to report side effects of prescription drugs to the FDA.
Visit www.fda.gov/safety/medwatch, or call 800-FDA-1088.

Please see full Prescribing Information, including Boxed WARNING, for INVEGA SUSTENNA®, INVEGA TRINZA®, and RISPERDAL CONSTA®, available at janssen.com/us/our-products.

© Janssen Pharmaceuticals, Inc. 2018

Patient Copy

Provider Instructions

1. **Have the patient read this form and check the box on page 3 of the Patient Enrollment Form if they wish to provide this Optional HIPAA Authorization.**
2. **Provide the patient with this sheet and a copy of page 3 of the Patient Enrollment Form, which they have signed.**

HIPAA Authorization for sharing Janssen CarePath patient data with payer:

I have enrolled in the Janssen CarePath program and have authorized certain health information about me to be disclosed to the company that administers Janssen CarePath, which is a third-party Program Administrator under contract with Janssen Pharmaceuticals, Inc. (referred to herein as "Program Administrator"). This health information ("Personal Information") includes information about the following:

- My diagnosis.
- The therapy prescribed to me (eg, INVEGA SUSTENNA® [paliperidone palmitate], INVEGA TRINZA® [paliperidone palmitate], or RISPERDAL CONSTA® [risperidone]).
- The patient offerings I have received from Janssen CarePath.

This Personal Information may reveal mental-health–related information about me. I now hereby authorize Janssen CarePath and Program Administrator to disclose this Personal Information to my health plan and its affiliates for purposes of:

- My case management and care coordination.
- The health plan's own data analysis, including to help my health plan to understand how I and others have used the Janssen CarePath program, how the Janssen CarePath program has impacted my health care and the care of others participating in the Janssen CarePath program, and the cost of such health care.

I understand that my health plan may create reports that do not identify me to share with Janssen CarePath. I understand that Janssen CarePath will not share my Personal Information with any other party for these purposes, except contractors who provide support for Janssen CarePath pursuant to contracts where those contractors agree to use the information only as described in this authorization, or as otherwise required by law.

I understand that, with respect to this authorization:

- I sign this authorization voluntarily. I understand that I may refuse to sign this authorization.
- I am entitled to a signed copy of this authorization for my records.
- I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance upon this authorization, and if not earlier revoked, this authorization will terminate on the sooner of (i) when I stop receiving Janssen CarePath patient offerings, or (ii) 10 years from the date of this authorization. To revoke, I understand that I must notify Janssen CarePath in writing at the following toll-free fax number: 877-785-1124. I understand that any revocation will not apply to information that has already been used and released in response to this authorization.
- The persons who receive my health information pursuant to this authorization may not be required by federal law (such as HIPAA) to protect it and may share my information with others if permitted by applicable law.
- I understand that I have the right to review any information that has been disclosed pursuant to this authorization upon written request to Janssen CarePath at the following toll-free fax number: 877-785-1124.

You are encouraged to report side effects of prescription drugs to the FDA. Visit www.fda.gov/safety/medwatch, or call 800-FDA-1088.

Please see full Prescribing Information, including Boxed WARNING, for INVEGA SUSTENNA®, INVEGA TRINZA®, and RISPERDAL CONSTA®, available at janssen.com/us/our-products.

© Janssen Pharmaceuticals, Inc. 2018