Janssen CarePath Savings Program
Patient Assignment of Benefits

1. **Please note that this completed form is required in order for the provider to receive a payment on behalf of the patient for medication costs.**
   - **When submitting an Explanation of Benefits (EOB), a copy of the Health Insurance Claim Form-CMS 1500 (HICF) or Uniform Billing Form-CMS 1450 (UB-04) must be included.**
2. **Effective 8/20/18, only providers with a JanssenCarePathPortal.com account will be able to submit this form. Visit JanssenCarePathPortal.com to create an account and upload this form online or fax it to 855-820-3224.**
3. **The patient who has directed that payment should be made to the provider must authorize the assignment of benefits by signing this form. All fields must be completed.**

Patient Information and Authorization

Patient: Date of Birth (mm/dd/yyyy):

Patient Address:

City: State: ZIP Code:

My signature on this Patient Assignment of Benefits Form confirms that I authorize my Janssen CarePath Savings Program benefits be sent on my behalf to the provider I have designated on this form for payment of my out-of-pocket Janssen medication cost. I also understand that I may, at any time, call Janssen CarePath and elect for the rebate check(s) to be sent directly to me or for my rebate to be loaded onto a debit card (if available).

Patient Signature: _____ Date: _____

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

By: _____ Date: _____

(Signature of person legally authorized to sign for patient)

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

Treatment Provider Information and Authorization

Site Name: CARY RHEUMATOLOGY & ARTHRITIS ASSOCIATES Site NPI: 1215239363

Provider First Name: Sanjay Provider Last Name: Chaudhary

Address: 1720 NW MAYNARD RD City: Cary State: NC ZIP: 27513

Site Phone: (919) 344-0180 Site Fax: (919) 851-1900

My signature on this Patient Assignment of Benefits Form acknowledges that the patient listed above has requested their benefit from the Janssen CarePath Savings Program be sent to our Treatment Site for payment of the patient's eligible out-of-pocket Janssen medication costs. I further understand that patient may elect in the future for a rebate check to be sent directly to the patient or for the rebate to be loaded onto a debit card (if available). At that point, the patient's Janssen CarePath Savings Program benefit will no longer be sent to our Treatment Site.

Treatment Site Representative Signature: Date:

Print Name: Vandna Chaudhary Treatment Site: Cary Rheumatology & Arthritis Associate

Please read the full Prescribing Information , including Boxed Warnings, and Medication Guide for SIMPONI ARIA®, and discuss any questions you have with your doctor.

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 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 866-489-5955 or mailed to Janssen CarePath, PO Box 15510, Pittsburgh, PA 15244**
- **You may be able to eSign a digital Form in your healthcare provider's office or on the Janssen CarePath Patient Account at MyJanssenCarePath.com**

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

I give permission for each of my "Healthcare Providers" (eg, my physicians, pharmacists, specialty pharmacies, other healthcare providers, and their staff) and "Insurers" (eg, my health insurance plans) to share my Protected Health Information as described on this Form.

My "Protected Health Information" includes any and all information related to my medical condition, treatment, prescriptions, and health insurance coverage.

The following person(s) or class of person(s) are given permission to receive and use my Protected Health Information (collectively "Janssen"):

- Johnson & Johnson Health Care Systems Inc., its affiliated companies, agents, and representatives
- Providers of other sources of funding, including foundations and co-pay assistance providers
- Service providers for the patient support programs, including subcontractors or healthcare providers helping Janssen run the programs
- Service providers maintaining, transmitting, de-identifying, aggregating, or analyzing data from Janssen patient support programs

Also, I give permission to Janssen to receive, use, and share my Protected Health Information in order to:

- see if I qualify for, sign me up for, contact me about, and provide services relating to Janssen patient support programs, including in-home services
- manage the Janssen patient support programs
- give me educational and adherence materials, information, and resources related to my Janssen medication in connection with Janssen patient support programs
- communicate with my Healthcare Providers regarding access to, reimbursement for, and fulfillment of my Janssen medication, and to tell my Healthcare Provider that I am participating in Janssen patient support programs
- verify, assist with, and coordinate my coverage for my Janssen medication with my Insurers and Healthcare Providers
- coordinate prescription or treatment location and associated scheduling
- conduct analysis to help Janssen evaluate, create, and improve its products, services, and customer support for patients prescribed Janssen medications
- share and give access to information created by the Janssen patient support programs that may be useful for my care

I understand that my Protected Health Information may be shared by Janssen for the uses written in this Form to:

- My Insurers
- My Healthcare Providers
- Any of the persons given permission to receive and use my Protected Health Information as mentioned above
- Any individual I give permission as an additional contact

Janssen 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.

Janssen Patient Support Program Patient Authorization Form

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, 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:

_____

