Information In Shaded Sections Is Required

Simponi® golimumab

Prescription Enrollment Form

UPDATE 9.15

Complete and fax this form to 1-855-224-5072 or mail to PO Box 218, Monroeville, PA 15146-2230.

1. PATIENT INFORMATION

NAME (First, MI, Last) ______ SEX ❑ M ❑ F

DOB (MM/DD/YYYY) ______ ADDRESS ______

CITY ______ STATE ______ ZIP CODE ______ E-MAIL ______

CELL PHONE ______ HOME PHONE ______ WORK PHONE ______

PREFERRED NUMBER TO CALL ❑ Cell ❑ Home ❑ Work BEST TIME TO CONTACT ❑ Morning ❑ Afternoon ❑ Evening

2. INSURANCE INFORMATION (Include alpha prefix and suffix with policy and group# when applicable or provide a copy of insurance card)

PRIMARY INSURANCE ______ CARDHOLDER ______

RELATIONSHIP TO CARDHOLDER ______ EMPLOYER ______ INS. CO. PHONE ______

POLICY# ______ GROUP# ______

SECONDARY INSURANCE ______ CARDHOLDER ______

RELATIONSHIP TO CARDHOLDER ______ EMPLOYER ______ INS. CO. PHONE ______

POLICY# ______ GROUP# ______

PRESCRIPTION DRUG INSURER ______ CARD/BIN# ______ PHONE ______

NOTE: Pharmacy benefit will be investigated. If patient does not have a pharmacy benefit, medical benefits will be investigated.

3. PATIENT AUTHORIZATION FOR SimponiOne® SUPPORT SERVICES (To be completed only when [1] there is not a valid Business Associate Agreement with the Covered Entity, or [2] the Covered Entity has signed a Limitation of Services request. Patient should read the Patient Authorization on the Patient Copy and sign below)

My signature below certifies that I have read, understand, and agree to the Patient Authorization to release my Protected Health Information to Janssen Biotech, Inc., its parent or affiliate, designee or successor, and specialty pharmacies and other service providers supporting AccessOne® and SimponiOne® Support as defined on the Patient Copy (collectively, "Janssen Biotech"). SimponiOne® Support Services are part of AccessOne®.

PATIENT SIGNATURE ______ DATE ______ PATIENT NAME ______

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)

4. PRIOR AUTHORIZATION SERVICES (Please check the appropriate box[es] below to request assistance with prior authorizations)

❑ **Prior Authorization Form Assistance** By checking this box, I request that AccessOne® assist my office in providing the requirements of this patient's health plan related to prior authorization for treatment with SIMPONI®. I understand that assistance includes obtaining the health plan-specific prior authorization form, and providing 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 AccessOne® for possible completion and submission to the health plan.

❑ **Prior Authorization Status Monitoring** By checking this box, I request that AccessOne® actively monitor the status of the prior authorization submission. I request that AccessOne® provide status updates to my office with respect to this patient's prior authorization for treatment with SIMPONI®.

5. PRESCRIBER INFORMATION

PRESCRIBER NAME (First, Last) ______

SPECIALTY ______

PRACTICE NAME ______ OFFICE CONTACT ______

ADDRESS ______

CITY ______ STATE ______ ZIP CODE ______

E-MAIL ______ PHONE ______ FAX ______

MEDICAID/MEDICARE PROVIDER# ______ TAX ID# ______

STATE LICENSE# ______ UPIN/NPI# ______

6. PRIOR MEDICATIONS

❑ Acetaminophen, ibuprofen, naproxen sodium, or other over-the-counter pain relievers ❑ Leflunomide ❑ Rituxan*

❑ 5-ASA	❑ Azulfidine*	❑ Corticosteroids	❑ Humira*	❑ Methotrexate	❑ Other
❑ 6-MP	❑ Calcipotriene	❑ Cyclophosphamine	❑ Hydroxychloroquine	❑ Naproxen	______
❑ Actemra*	❑ Celebrex*	❑ Cyclosporine	❑ Indocin*	❑ Orencia*	
❑ Azathioprine	❑ Cimzia*	❑ Enbrel*	❑ Kineret*	❑ Penicillamine	

7. CLINICAL INFORMATION (Required. If requesting benefit investigation after September 30, 2015, use ICD-10 codes. Visit JanssenAccessOne.com for ICD-9 conversion to ICD-10 or consult the ICD-10 code book for additional information)

■ **PRIMARY DIAGNOSIS: Ulcerative Colitis**

DIAGNOSIS CODE ______ INDICATION ______

■ **SECONDARY DIAGNOSIS: Ulcerative Colitis**

DIAGNOSIS CODE ______ INDICATION ______

DIAGNOSIS CODE ______ INDICATION ______

TB TEST (DATE) ______ HEPATITIS B VIRUS TEST (DATE) ______ DATE OF DIAGNOSIS OR YEARS WITH DISEASE ______

8. PRESCRIPTION INFORMATION (If requesting benefits investigation only, do not complete this section. The prescription is only valid if received by fax. SPECIAL NOTE: New York Prescribers please submit prescription on an original NY State prescription blank. For all other states, if not faxed, prescription must be submitted on state-specific blank, if applicable for your state)

■ **Rx: SIMPONI® (golimumab)**

DIRECTIONS: ULCERATIVE COLITIS—STARTER DOSES (200 mg at Week 0; 100 mg at Week 2)

❑ 3 Single-use autoinjectors, 100 mg/1.0 mL SC

DIRECTIONS: ULCERATIVE COLITIS—MAINTENANCE THERAPY (100 mg every 4 weeks)

❑ 1 Single-use autoinjector, 100 mg/1.0 mL SC Refills # ______

❑ OTHER ______ Refills # ______

SHIP TO: ❑ PROVIDER OFFICE—Initial injection only

❑ PATIENT'S HOME—I have instructed the patient in proper injection technique for SIMPONI® and the patient will self-administer

❑ OTHER

NAME (if different than above) ______

ADDRESS ______ CITY ______ STATE ______

ZIP CODE ______ PHONE ______ FAX ______

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

SUPERVISING PHYSICIAN SIGNATURE (if applicable) ______ DATE ______

SUPERVISING PHYSICIAN NAME ______

9. PREFERRED SPECIALTY PHARMACY (Provider to check one below)

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 as checked 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.

❑ Accredo/CuraScript	❑ Aetna	❑ CVS Caremark	❑ Walgreens/BioScrip
❑ Cigna Tel-Drug	❑ Optum Rx (Prescription Solutions)	❑ Advanced Care Scripts	❑ Diplomat
❑ Prime Specialty	❑ Total Life Care Pharmacy	❑ Senderra Rx	❑ Encompass Rx

❑ Other ______

*Indicated trademarks are registered trademarks of their respective owners. Actemra® (tocilizumab), Azulfidine® (sulfasalazine), Celebrex® (celecoxib), Cimzia® (certolizumab pegol), Enbrel® (etanercept), Humira® (adalimumab), Indocin® (indomethacin), Kineret® (anakinra), Orencia® (abatacept), Rituxan® (rituximab).

Before prescribing SIMPONI®, please see full Prescribing Information, including Boxed Warnings, and Medication Guide for SIMPONI®, available at www.SIMPONI.com. For assistance or additional information, call 1-888-ACCESS-1 (1-888-222-3771), Monday–Friday, 8:00 AM–8:00 PM, ET

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Patient insurance benefit investigation is provided as a service by The Lash Group, Inc., under contract for Janssen Biotech, Inc. In this regard, The Lash Group, Inc., assists healthcare professionals in the determination of whether treatment could be covered by the applicable third-party payer based on coverage guidelines provided by the payer and patient information provided by the healthcare provider under appropriate authorization following the provider's exclusive determination of medical necessity.

Importantly, insurance verification is the ultimate responsibility of the provider. Third-party reimbursement is affected by many factors. Therefore, The Lash Group, Inc., and Janssen Biotech, make no representation or guarantee that full or partial insurance reimbursement or any other payment will be available. This information is provided as an information service only. While The Lash Group, Inc., tries to provide correct information, they and Janssen Biotech, make no representations or warranties, expressed or implied, as to the accuracy of the information. In no event shall The Lash Group, Inc., or Janssen Biotech, or its employees or agents be liable for any damages resulting from or relating to the services.

All providers and other users of this information agree that they accept responsibility for the use of this service.

Janssen Biotech assumes no responsibility for, and does not guarantee the quality, scope, or availability of the services including but not limited to reimbursement support services, coordination of prescription fulfillment, patient education, and other support services. Each provider, not Janssen Biotech, is responsible for the services they provide. These support services have no independent value to providers apart from the product and are included within the cost of the product.

Before prescribing SIMPONI® (golimumab), please see full Prescribing Information, including Boxed Warnings, and Medication Guide, available at www.SIMPONI.com.

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janssen

PHARMACEUTICAL COMPANIES OF Johnson & Johnson

Patient Copy

<u>Provider Instructions</u>

1. **Have the patient read this form and sign the acknowledgements on the front of the Prescription Enrollment Form for SIMPONI® (golimumab) relating to the Patient Authorization.**
2. **Provide the patient with this sheet and a copy of the front of the Prescription Enrollment Form for SIMPONI®, which the patient has signed.**

PATIENT AUTHORIZATION (PA)

My signature on the front of the Prescription Enrollment Form for SIMPONI® confirms that I authorize each of my physicians, pharmacists, including any specialty pharmacy that receives my prescription for SIMPONI®, and other healthcare providers (together, "Healthcare Providers") and each of my health insurers (together, "Insurers") to disclose my Protected Health Information, including but not limited to medical records, information related to my medical condition and treatment, my health insurance coverage, my name, address, telephone number, Social Security number, insurance plan and or group numbers (together, "Protected Health Information") to Janssen Biotech, Inc., its affiliated companies, agents and representatives, including providers of alternate sources of funding for prescription drug costs, and other service providers supporting access programs for Healthcare Providers (AccessOne®) and patients (SimponiOne® Support) (together, "Janssen Biotech") for the purposes described below.

Specifically, I authorize Janssen Biotech to receive, use, and disclose my Protected Health Information in order to (i) enroll me in, and contact me about, SimponiOne® Support programs; (ii) provide me with educational materials, information, and services related to SIMPONI®; (iii) verify, investigate, assist with, and coordinate my coverage for SIMPONI® with my Insurers; (iv) coordinate prescription fulfillment; and (v) assist with analyses related to the quality, efficacy, and safety of SIMPONI®, and patient access to and adherence to SIMPONI®. I also understand that pharmacies that ship my medication may be paid to share this information with SimponiOne® Support to help provide the offerings requested for me. Furthermore, I understand that my Protected Health Information will not be used or disclosed by Janssen Biotech for any other purpose unless permitted by law or unless information that specifically identifies me is removed. I understand that Janssen Biotech will make every effort to keep my information private. If my information is accidentally shared, federal privacy laws do not require that the person/party receiving it not disclose the information further. Information disclosed under these circumstances and provided to a third party may no longer be protected by federal privacy laws. For additional information on how Janssen Biotech collects, uses, and discloses personal information, visit www.janssenbiotech.com/privacy-policy.

I understand that I am not required to sign the front of the Prescription Enrollment Form for SIMPONI®. My choice about whether to sign will not change the way my Healthcare Providers or Insurers treat me. If I refuse to sign the front of the Prescription Enrollment Form for SIMPONI®, or revoke my authorization later, I understand that this means I will not be able to participate or receive assistance from AccessOne® or SimponiOne® Support.

This authorization will last until I am no longer participating in SimponiOne® Support Services. I understand that I may cancel this Authorization at any time by mailing a letter requesting such cancellation to AccessOne®, c/o The Lash Group, Inc., PO Box 218, Monroeville, PA 15146-2230. I can also revoke my authorization by informing my Healthcare Providers and Insurers in writing that I do not want them to share any information with Janssen Biotech, but this will not affect Janssen Biotech's ability to use and disclose Protected Health Information that it has received prior to its receipt of notification that I wish to discontinue my participation in the program. My authorization will also end if AccessOne® and SimponiOne® Support are discontinued. Furthermore, I understand that I have the right to see or copy the Protected Health Information my Healthcare Providers or Insurers have given to Janssen Biotech.

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.fda.gov/medwatch, or call 1-800-FDA-1088.
Please read the Medication Guide for SIMPONI® and discuss any questions or concerns with your doctor.

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