PATIENT ASSISTANCE PROGRAM APPLICATION
To Be Completed By Patient

Johnson & Johnson PATIENT ASSISTANCE FOUNDATION, INC.

To apply for assistance, please mail or fax the following items:

- **Complete Patient Page**
- **Complete Products to be Distributed Page**
- **Complete Physician Page**
- **Signed Patient Declaration and Authorization Page**
- **Copy of Patient's most recent federal tax return**

Mail to: Patient Assistance Program
PO Box 221857
Charlotte, NC 28222-1857
Telephone: 800-652-6227
Fax: 888-526-5168

PATIENT INFORMATION

Name: _____ Primary Telephone: _____

Address, City, State, ZIP _____

Date of Birth: _____ Social Security #: _____

Email: _____ Gender: ☐ Male ☐ Female

FINANCIAL INFORMATION (All Values Should Reflect Yearly Amounts for Entire Household)

Total Gross Yearly Income $ _____

Household Size: _____
(Number of people who contribute to or are dependent on your household income)

Check the applicable box:

☐ **Attached is a copy of my most recent federal tax return**

☐ **I do not file federal taxes**

Your application may be subject to audit or request for additional documentation.

INSURANCE INFORMATION

Do you have any public or private insurance? ☐ Yes ☐ No

MEDICARE

Are you eligible for Medicare? ☐ Yes ☐ No

Medicare Policy # _____

Are you enrolled in a Medicare prescription drug plan? ☐ Yes ☐ No

Value of Assets $_____ (To determine eligibility for Part D Low Income Subsidy [LIS])

(Include: checking & savings accounts, certificates of deposits, stocks & bonds, mutual funds, IRAs, cash, and the value of life insurance policies if you turned in your policies for cash right now. Do not include: homes, vehicles, burial plots or personal possessions.)

Insurance Company: _____ Plan Name # _____

Telephone: _____ Policy ID # _____

MEDICAID

Are you eligible for Medicaid? ☐ Yes ☐ No

If "Yes", are you eligible for prescription drug benefits? ☐ Yes - Medicare Savings Program-Only (e.g., QMB, SLMB, QI-1)

☐ No - Spend-down not reached

OTHER STATE/ GOVERNMENT

Are you eligible for other state/government programs that provide prescription drug benefits (e.g., ADAP, SPAP – State Patient Assistant Program)? ☐ Yes ☐ No ☐ Applied ☐ Not Applied ☐ Application Pending ☐ Waitlist ☐ Unsure

PRIVATE/HMO

Insurance Company: _____ Telephone: _____

Policy ID # _____ Group ID # _____ Subscriber Name: _____

Does this policy cover prescription drugs? ☐ Yes ☐ No Date of Birth: _____ Relation to Patient: _____

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Patient Name: _____

PRODUCTS TO BE DISTRIBUTED (Check all applicable)
THIS PROGRAM IS LIMITED TO PATIENTS BEING TREATED ON AN OUTPATIENT BASIS

PHARMACY CARD DISTRIBUTION - Patients receiving assistance through the Pharmacy Card will need a valid prescription from their prescribing physician to access medication.

- ☐ AXERT® (almotriptan malate) Tablets
- ☐ CONCERTA® (methylphenidate HCl) Extended-Release Tablets CII
- ☐ DITROPAN® XL (oxybutynin chloride) Extended Release Tablets
- ☐ DURAGESIC® (fentanyl transdermal system) CII
- ☐ ELMIRON® (pentosan polysulfate sodium) Capsules
- ☐ INVOKANA™ (canagliflozin) Tablets
- ☐ LEVAQUIN® (levofloxacin) Tablets/Oral Solution
- ☐ NUCYNTA® (tapentadol) immediate-release oral tablets C-II
- ☐ NUCYNTA® ER (tapentadol extended-release oral tablets)
- ☐ OLYSIO™ (simeprevir) Capsules
- ☐ PREZISTA® (darunavir) Oral Suspension
- ☐ RAZADYNE® (galantamine HBr) Tablets/Oral Solution
- ☐ RAZADYNE® ER (galantamine HBr) Extended-Release Capsules
- ☐ SIMPONI® (golimumab) Injection
- ☐ SPORANOX® (itraconazole) Capsules
- ☐ TOPAMAX® (topiramate) Sprinkle Capsules
- ☐ TOPAMAX® (topiramate) Tablets
- ☐ ULTRACET® (tramadol hydrochloride/acetaminophen) Tablets
- ☐ ULTRAM® (tramadol hydrochloride) Tablets
- ☐ ULTRAM® ER (tramadol HCL) Extended-Release Tablets
- ☐ XARELTO® (rivaroxaban)
- ☐ ZYTIGA® (abiraterone acetate) Tablets

Please check box to indicate if patient is currently on PREZISTA® ☐

DIRECT TO PHYSICIAN DISTRIBUTION – Medications selected for Direct to Physician Distribution will be shipped to the physician's office. Patients deemed eligible for the Program are eligible for up to 12 months of assistance as long as they continue to meet eligibility requirements.

- ☐ DOXIL® (doxorubicin HCL liposome injection) for intravenous infusion
- ☐ HALDOL® (haloperidol) Injection
- ☐ HALDOL® (haloperidol) Decanoate Injection
- ☐ INVEGA® SUSTENNA® (paliperidone palmitate) Extended-Release Injectable Suspension
- ☐ NATRECOR® (nesiritide) for Injection
- ☐ ORTHOVISC® High Molecular Weight Hyaluronan
- ☐ PARAFON FORTE® DSC (chlorzoxazone) Caplets
- ☐ REMICADE® (infliximab) for IV Injection
- ☐ RISPERDAL® CONSTA® (risperidone) Long-Acting Injection
- ☐ SIMPONI® ARIA™ (golimumab) for Infusion
- ☐ SPORANOX® (itraconazole) Oral Solution
- ☐ TERAZOL® 3 (terconazole) Vaginal Cream or Suppositories
- ☐ TERAZOL® 7 (terconazole) Vaginal Cream

DIRECT TO PATIENT DISPENSE – Medications selected for Direct to Patient Dispense will be shipped to the patient's residence. Patients deemed eligible for the Program are eligible for up to 12 months of assistance as long as they continue to meet eligibility requirements.

- ☐ IMBRUVICA™ (ibrutinib) Capsules

PHARMACY CARD OR DIRECT TO PHYSICIAN DISTRIBUTION - Check the preferred method of distribution when selecting products below. See limitations above.

INVEGA® (paliperidone) Extended-Release Tablets	☐ Pharmacy Card	or	☐ Direct to Physician
PANCREAZE® (pancrelipase) Delayed-Release Capsules	☐ Pharmacy Card	or	☐ Direct to Physician
PROCRIT® (epoetin alfa) FOR INJECTION	☐ Pharmacy Card	or	☐ Direct to Physician

If requesting PROCRIT®, is patient being treated on renal dialysis? YES ☐ **NO** ☐

RISPERDAL® (risperidone) Tablets/ Oral Solution	☐ Pharmacy Card	or	☐ Direct to Physician
RISPERDAL® (risperidone) M-TAB® Orally Disintegrating Tablets	☐ Pharmacy Card	or	☐ Direct to Physician
STELARA® (ustekinumab) Injection	☐ Pharmacy Card	or	☐ Direct to Physician
EDURANT® (rilpivirine) Tablets	☐ Pharmacy Card	or	☐ Direct to Physician
PREZISTA® (darunavir) Tablets	☐ Pharmacy Card	or	☐ Direct to Physician
INTELENCE® (etravirine) Tablets	☐ Pharmacy Card	or	☐ Direct to Physician

Please check box to indicate if patient is currently on PREZISTA® ☐ **INTELENCE®** ☐ **or EDURANT®** ☐

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Johnson & Johnson PATIENT ASSISTANCE FOUNDATION, INC

ICD-9 Code (Required for Physician Administered Products Only)

Patient Name: _____ _____ ; _____

PHYSICIAN INFORMATION

Physician Name: _____ Telephone: _____

Facility Name: _____ Fax: _____

Office Contact Name: _____ Tax ID #: _____

Email: _____ National Provider ID #: _____

Address City, State, ZIP: _____

DIRECT TO PHYSICIAN DELIVERY ADDRESS

If the shipping address is different from the physician's address, provide the shipping address below.

Facility Name: _____ Telephone: _____ Fax: _____

Facility Contact Name: _____ Business Hours: _____

Address, City, State, ZIP: _____

PRESCRIBING INFORMATION (Attach additional prescription if more than two products are selected for Direct to Physician Distribution)

Patient Name: _____

Product #1 Name _____ Product #2 Name _____

Dosage: _____ Sig: _____ Dosage: _____ Sig: _____

Quantity: _____ Days Supply: _____ Quantity: _____ Days Supply: _____

Date: _____ Date: _____

Number of Refills (maximum 12): _____ Number of Refills (maximum 12): _____

State License # (required): _____ **Physician DEA # (required):** _____

For IMBRUVICA™ patients, please complete this additional section:

Allergies ☐ **NKDA or List:** _____

Current Therapies/Medications ☐ **None or List** _____

_____

NOTICE: For New York State Prescribers, please provide order for IMBRUVICA™ on your NYS official prescription form.

Johnson & Johnson Patient Assistance Foundation (JJPAF) policy prohibits physicians from charging the patient any fee for enrollment or other activities associated solely with the patient's participation in this patient assistance program (Program). JJPAF requests that physicians 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. The product(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.** Please indicate your agreement to the terms of Program participation by signing below. In addition, your signature is intended to confirm to JJPAF that: (1) there is a valid medical need for this patient's prescription; (2) that to the best of your knowledge this patient does not have prescription drug insurance coverage (including Medicare, Medicaid, county funded, or other public programs) for the product(s) listed above; and (3) you are not prohibited from participating in Federally-funded health care programs nor are you on the List of Excluded Individuals/Entities maintained by the HHS Office of Inspector General.

Physician Signature: **Date:**

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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 (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.

Patient Authorization To Share Health Information

I allow my doctor(s), any health care providers, and my health plan or insurers to give medical information relating to my use or need for products provided under the Johnson & Johnson Patient Assistance Foundation (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 or the Program administrator 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
- 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
- I can withdraw this consent at any time but it will not change any actions taken before I withdrew consent
- I have a right to see or copy information given to JJPAF or Program Administrators
- This Authorization will last until I am no longer participating in the Program

I KNOW THAT I MAY REFUSE TO SIGN THIS FORM. My choice about whether to sign this form will not change the way health care providers or insurers treat me. If I refuse to sign this form, I know that this means I may no longer be able to receive assistance from the Program.

Patient Name (Print): _____ **Date:** _____

Patient Signature: _____
If the patient cannot sign, patient's personal representative must sign below

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

Patient Authorization To Elect Representative for Purposes of Program Enrollment (if applicable)

I permit the Johnson & Johnson Patient Assistance Foundation (JJPAF) to speak with the following person about my application. This includes discussing the status of my application, insurance and financial questions, missing documentation, if any, and any other issues related to my application.

Name of Authorized Representative:_____ Telephone:_____

Organization Name:_____ Email:_____

By signing below, you allow this representative to speak on your behalf on any matter regarding your application with JJPAF:

Patient Signature:_____ Date:_____

A copy of this form must be provided to the patient.