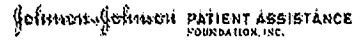


PATIENT ASSISTANCE PROGRAM APPLICATION
To Be Completed By Patient



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 \$ _____ Check the applicable box:
 Household Size: _____ Attached is a copy of my most recent federal tax return
 (Number of people who contribute to or are dependent on your household I do not file federal taxes
 income)
Your application may be subject to audit or request for additional documentation.

INSURANCE INFORMATION

Do you have any public or private insurance? Yes No

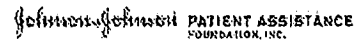
MEDICARE Are you eligible for Medicare? Yes No
 Medicare Policy # _____
 Are you enrolled in a Medicare prescription drug plan? Yes No
 Value of Assets \$ _____ (To determine eligibility for Part D Low Income Subsidy [LIS])
 (Include: checking & savings accounts, certificates of deposits, stocks & bonds, 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: _____

PATIENT ASSISTANCE PROGRAM APPLICATION
To Be Completed By Physician



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.

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

- | | |
|--|---|
| <input type="checkbox"/> DOXIL [®] (doxorubicin HCL liposome injection) for intravenous infusion
<input type="checkbox"/> HALDOL [®] (haloperidol) Injection
<input type="checkbox"/> HALDOL [®] (haloperidol) Decanoate Injection
<input type="checkbox"/> INVEGA [®] SUSTENNA [®] (paliperidone palmitate) Extended-Release Injectable Suspension
<input type="checkbox"/> NATRECOR [®] (nesiritide) for Injection
<input type="checkbox"/> ORTHOVISC [®] High Molecular Weight Hyaluronan | <input type="checkbox"/> PARAFON FORTE [®] DSC (chlorzoxazone) Caplets
<input type="checkbox"/> REMICADE [®] (infliximab) for IV Injection
<input type="checkbox"/> RISPEDAL [®] CONSTA [®] (risperidone) Long-Acting Injection
<input type="checkbox"/> SIMPONI [®] ARIA [™] (golimumab) for Infusion
<input type="checkbox"/> SPORANOX [®] (itraconazole) Oral Solution
<input type="checkbox"/> TERAZOL [®] 3 (terconazole) Vaginal Cream or Suppositories
<input type="checkbox"/> 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.

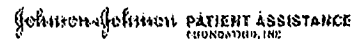
- IMBRUVICA[™] (ibrutinib) Capsules

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 | <input type="checkbox"/> Pharmacy Card | or | <input type="checkbox"/> Direct to Physician | |
| PANCREAZE [®] (pancrelipase) Delayed-Release Capsules | <input type="checkbox"/> Pharmacy Card | or | <input type="checkbox"/> Direct to Physician | |
| PROCRIT [®] (epoetin alfa) FOR INJECTION | <input type="checkbox"/> Pharmacy Card | or | <input type="checkbox"/> Direct to Physician | |
| If requesting PROCRI[®], is patient being treated on renal dialysis? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| RISPEDAL [®] (risperidone) Tablets/ Oral Solution | <input type="checkbox"/> Pharmacy Card | or | <input type="checkbox"/> Direct to Physician | |
| RISPEDAL [®] (risperidone) M-TAB [®] Orally Disintegrating Tablets | <input type="checkbox"/> Pharmacy Card | or | <input type="checkbox"/> Direct to Physician | |
| STELARA [®] (ustekinumab) Injection | <input type="checkbox"/> Pharmacy Card | or | <input type="checkbox"/> Direct to Physician | |
| EDURANT [®] (rilpivirine) Tablets | <input type="checkbox"/> Pharmacy Card | or | <input type="checkbox"/> Direct to Physician | |
| PREZISTA [®] (darunavir) Tablets | <input type="checkbox"/> Pharmacy Card | or | <input type="checkbox"/> Direct to Physician | |
| INTELENCE [®] (etravirine) Tablets | <input type="checkbox"/> Pharmacy Card | or | <input type="checkbox"/> Direct to Physician | |

Please check box to indicate if patient is currently on PREZISTA[®] INTELENCE[®] or EDURANT[®]

PATIENT ASSISTANCE PROGRAM APPLICATION
To Be Completed By Physician



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 _____

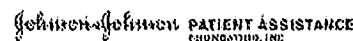
NOTICE: For New York State Prescribers, please provide order for IMBRUVICA™ on your NYS official prescription form.

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:

PATIENT ASSISTANCE PROGRAM APPLICATION
To Be Completed By Patient



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.