Patient Assistance Program Application

Johnson & Johnson PATIENT ASSISTANCE FOUNDATION, INC.

TO BE COMPLETED BY THE PATIENT

To apply for assistance all information must be complete and include the following steps:

- ☐ Complete pages 1 and 2 and sign the Patient Declaration and Authorization to Share information on page 2
- ☐ Ask your physician to complete pages 3-4 and sign page 4
- ☐ Include a copy of your most recent 1040 or 1040EZ federal tax return

Fax to: 1-888-526-5168 **or**
Mail to: Johnson & Johnson Patient Assistance Foundation, Inc.
Patient Assistance Program
P.O. Box 221857, Charlotte, NC 28222-1857
If you have any questions, call 1-800-652-6227

1 Patient Information

Name: ____________________ Telephone: ____________________ Email: ____________________

Social Security #: ____________________ Date of Birth: ____________________ Gender: ☐ Male ☐ Female

Address (Street, City, State, ZIP): ____________________

2 Financial Information

Federal Taxes

☐ A copy of my most recent 1040 or 1040EZ Federal tax return is attached.

☐ I do not file federal taxes.

(Tax returns may be reviewed and additional documentation requested.)

Total Gross Yearly Income
Entire Household: $ ____________________

Household Size: The number of people who live in your home and are dependent on your household income: __________

3 Healthcare Insurance Information *(Select all that apply.)*

☐ **I do not have healthcare insurance**

☐ **Private/HMO insurance**

Insurance Company: ____________________

Policy ID #: ____________________

Group ID #: ____________________

Phone #: ____________________

Subscriber Name: ____________________

Date of Birth: ____________________

Relation to Patient: ____________________

Does the policy cover prescription drugs?
☐ Yes
☐ No
☐ Unsure

☐ **Medicare insurance**

Insurance Company: ____________________

Medicare Policy #: ____________________

Plan Name: ____________________

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

Part D Policy #: ____________________

Part D Plan Name: ____________________

Phone #: ____________________

☐ **Medicaid insurance**

Policy #: ____________________

Plan Name: ____________________

Phone #: ____________________

☐ **Other state/government insurance**

Veterans Affairs (VA)
Policy #: ____________________
Plan Name: ____________________
☐ My application is pending
Phone #: ____________________

ADAP AIDS Drug Assisted Program
Policy #: ____________________
Plan Name: ____________________
☐ My application is pending
☐ I am on a waiting list

SPAP State Patient Assistance Program
Policy #: ____________________
Plan Name: ____________________
☐ My application is pending

Other:
Policy #: ____________________
Plan Name: ____________________
☐ My application is pending
Phone #: ____________________

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TO BE COMPLETED BY THE PATIENT: Patient should keep a copy of this page

4 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, Inc. (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 related to my use or need for products provided under the 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 by contacting JJPAF at 1-800-652-6227 at any time, but it will not change any actions taken before I withdraw consent.
- I have a right to see or copy information given to JJPAF or the Program Administrators.
- Specifically, I authorize JJPAF to contact me to request my assistance with analysis related to the quality and efficacy of the JJPAF program.
- 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 that I may no longer be able to receive assistance from the Program.**

Patient Name (print): ____________________ **Patient Signature:** ____________________ Date

If applicable, your representative or Power of Attorney must sign below.

Patient Representative Name: ____________________ Signature: ____________________ Date

Contact information: ____________________

Relationship to patient and authority to make medical decisions for patient: ____________________

Power of Attorney Name: ____________________ **Signature:** ____________________ Date

Contact information: ____________________

We will contact you if additional documentation is required.

5 If applicable: Patient Authorization to Elect Representative for Purposes of Program Enrollment

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

Name of Authorized Representative: ____________________ Organization Name: ____________________

Telephone: ____________________ Email: ____________________

By signing below, I am allowing this representative to speak on my behalf on any matter regarding my application with JJPAF.

Patient Signature: ____________________ Date

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TO BE COMPLETED BY THE PHYSICIAN

1 Products to be distributed (Select all that apply). This program is limited to patients being treated on an **outpatient basis.**

Patient Name: ____________________

Product	Form	**Pharmacy Card** Pharmacy pick up. Physician must provide a prescription.	**Direct to Physician** Shipped to the physician's office.	**Direct to Patient** Shipped to the patient's residence.
AXERT® (almotriptan malate)	Tablets	☐	N/A	N/A
CONCERTA®† (methylphenidate HCl)	Extended-release tablets CII	☐	N/A	N/A
DITROPAN® XL (oxybutynin chloride)	Extended-release tablets	☐	N/A	N/A
DOXIL®† (doxorubicin HCl liposome)	Intravenous infusion	N/A	☐	N/A
DURAGESIC®† (fentanyl)	Transdermal system CII	☐	N/A	N/A
EDURANT® (rilpivirine)	Tablets	☐	☐	N/A
ELMIRON® (pentosan polysulfate sodium)	Capsules	☐	N/A	N/A
HALDOL®† (haloperidol)	Injection for immediate-release	N/A	☐	N/A
HALDOL®† Decanoate (haloperidol)	Injection for extended-duration for effect	N/A	☐	N/A
IMBRUVICA® (ibrutinib)	Capsules	N/A	N/A	☐
INTELENCE® (etravirine)	Tablets	☐	☐	N/A
INVEGA®† (paliperidone)	Extended-release tablets	☐	☐	N/A
INVEGA SUSTENNA®† (paliperidone palmitate)	Extended-release injectable suspension	N/A	☐	N/A
INVEGA TRINZA™† (paliperidone palmitate)	Extended-release injectable suspension	N/A	☐	N/A
INVOKAMET® (canagliflozin + metformin)	Tablets	☐	N/A	N/A
INVOKANA® (canagliflozin)	Tablets	☐	N/A	N/A
LEVAQUIN®† (levofloxacin)	☐ Tablets or ☐ Oral solution	☐	N/A	N/A
MONOVISC® (high molecular weight hyaluronan)	Injection	N/A	☐	N/A
NATRECOR® (nesiritide)	Intravenous infusion	N/A	☐	N/A
NUCYNTA® (tapentadol)	Immediate-release tablets CII	☐	N/A	N/A
NUCYNTA® ER† (tapentadol)	Extended-release oral tablets CII	☐	N/A	N/A
OLYSIO® (simeprevir)	Capsules	☐	N/A	N/A
ORTHOVISC® (high molecular weight hyaluronan)	Injection	N/A	☐	N/A
PANCREAZE® (pancrelipase)	Delayed-release capsules	☐	☐	N/A
PARAFON FORTE® DSC (chlorzoxazone)	Caplets	N/A	☐	N/A
PREZCOBIX™ (darunavir 800mg/cobicistat 150mg)	Tablets	☐	☐	N/A
PREZISTA® (darunavir)	Tablets	☐	N/A	N/A
PREZISTA® (darunavir)	Injection	☐	☐	N/A
PROCRIT®† (epoetin alfa)	Injection	☐	☐	N/A
Required: Is the patient being treated on renal dialysis?	☐ Yes* ☐ No			
RAZADYNE® (galantamine HBr)	☐ Tablets or ☐ Oral solution	☐	N/A	N/A
RAZADYNE® ER (galantamine HBr)	Extended-release capsules	☐	N/A	N/A
REMICADE®† (infliximab)	Intravenous Infusion	N/A	☐	N/A
RISPERDAL®† (risperidone)	☐ Tablets or ☐ Oral solution	☐	☐	N/A
RISPERDAL CONSTA®† (risperidone)	Long-acting injection	N/A	☐	N/A
RISPERDAL® M-TAB®† (risperidone)	Orally disintegrating tablets	☐	☐	N/A
SIMPONI®† (golimumab)	☐ SmartJect® or ☐ prefilled syringe	☐	N/A	N/A
SIMPONI ARIA®† (golimumab)	Intravenous Infusion	N/A	☐	N/A
SPORANOX®† (itraconazole)	Capsules	☐	N/A	N/A
SPORANOX®† (itraconazole)	Oral solution	N/A	☐	N/A
STELARA® (ustekinumab)	Injection	☐	☐	N/A
SYLVANT® (siltuximab)	Intravenous Infusion	N/A	☐	N/A
TERAZOL® 3 (terconazole)	Cream	N/A	☐	N/A
TERAZOL® 7 (terconazole)	Cream	N/A	☐	N/A
TOPAMAX® (topiramate)	☐ Tablets or ☐ Sprinkle capsules	☐	N/A	N/A
ULTRACET®† (tramadol HCl/acetaminophen)	Tablets CIV	☐	N/A	N/A
ULTRAM® (tramadol HCl)	Tablets CIV	☐	N/A	N/A
ULTRAM® ER (tramadol HCl)	Extended-release tablets CIV	☐	N/A	N/A
XARELTO®† (rivaroxaban)	Tablets	☐	N/A	N/A
ZYTIGA® (abiraterone acetate)	Tablets	☐	N/A	N/A

*Contact Amgen Inc. 1-800-772-6436. † See full U.S. prescribing information, including Black Box warning.

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