Stelara withMe | Stelara® (ustekinumab)

Benefits Investigation and Prescription Enrollment Form

UPDATE 12.23

Complete and fax this form to 866-769-3903. For assistance, prescribers can call 844-4withMe (844-494-8463), Monday–Friday, 8:00 AM–8:00 PM ET
Please be sure to have your patient complete the Patient Authorization Form and submit it with this completed Benefits Investigation and Prescription Enrollment Form.

The information you provide will be used by Janssen Biotech, Inc., our affiliates, and our service providers for your patient's enrollment and participation in STELARA withMe via Janssen CarePath. Our **Privacy Policy** governs the use of the information you provide. By submitting this form, you indicate that you read, understand, and agree to these terms.

▼ TO BE COMPLETED BY PATIENT OR PROVIDER ▼

1. Patient Information (Required)

NAME (First, M, Last) _____ DOB (MM/DD/YYYY)_____ GENDER _____

ADDRESS _____ CITY _____

STATE _____ ZIP CODE _____ PHONE _____ EMAIL ADDRESS _____

As part of your patient's enrollment in STELARA withMe, they will have access to a dedicated Nurse Navigator at no cost to them. After submitting this form, your patient can expect a call from their STELARA withMe Nurse Navigator within 1 to 2 business days.

2. STELARA withMe Nurse Navigator Team Outreach

The STELARA withMe program offers a dedicated Nurse Navigator team at no cost to eligible patients over 18 with a prescription for approved on-label use. After submitting this form, your patient can expect to receive a phone call from the STELARA withMe Nurse Navigator team within 1-2 business days. A Nurse Navigator will describe the program to your patient and complete the enrollment process. A STELARA withMe Nurse Navigator cannot reach out to your patient without a signed Patient Authorization Form, which can be found on pages 3 and 4 of this document, unless you check the box below.

If you have a BAA on file, and no Patient Authorization form is being submitted, please check the box below for your patient to receive a call from a STELARA withMe Nurse Navigator:

☐ I represent that I have authorization from the patient that complies with state and federal law and permits me to provide their information for this purpose.

3. Insurance Information (Required. Complete fields below OR provide a copy of insurance cards.)

Medical Insurance _____ POLICY# _____ GROUP# _____

CARDHOLDER _____ DOB (MM/DD/YYYY) _____

Pharmacy Insurance _____ PCN# _____ GROUP# _____

CARDHOLDER _____ CARD/BIN# _____ DOB (MM/DD/YYYY) _____

Secondary Insurance _____ POLICY# _____ GROUP# _____

CARDHOLDER _____ DOB (MM/DD/YYYY) _____

▼ TO BE COMPLETED BY PROVIDER ▼

4. Prescriber Information (Required)

PRESCRIBER NAME (First, Last) _____ OFFICE CONTACT _____

PRACTICE NAME _____ TAX ID# _____ NPI# _____

ADDRESS _____ CITY _____

STATE _____ ZIP CODE _____ PHONE _____ FAX _____

5. Clinical Information (Required. The information requested is for benefits investigation purposes only.)

STELARA®—DIAGNOSIS

DATE OF DIAGNOSIS OR YEARS WITH DISEASE _____ PREVIOUS TB TEST (DATE) _____

☐ K50.00 (Crohn's Disease of small intestine, without complications)
☐ K50.80 (Crohn's Disease of both small and large intestine, without complications)
☐ K50.90 (Crohn's Disease, unspecified, without complications)
☐ K51.90 (Ulcerative Colitis, unspecified, without complications)
☐ K51.00 (Ulcerative [chronic] Pancolitis, without complications)
☐ K51.80 (Other Ulcerative Colitis, without complications)
☐ Other ICD-10 Code _____

PRIOR MEDICATIONS (REQUIRED TO COMPLETE PRIOR AUTHORIZATION)

☐ 5-ASA ☐ 6-MP ☐ Azathioprine ☐ Azulfidine® ☐ Cimzia® ☐ Corticosteroids ☐ Cyclosporine
☐ Entyvio® ☐ Humira® ☐ Methotrexate ☐ Tysabri® ☐ Xeljanz® ☐ Zeposia® ☐ None ☐ Other _____

6. Prior Authorization

Prior Authorization Form Assistance and Status Monitoring: STELARA withMe assists your office in providing the requirements of the patient's health plan related to prior authorization for treatment with STELARA®. Assistance includes obtaining the health plan-specific prior authorization form, and providing it based upon the patient-specific information provided on this form. The partially completed prior authorization form will be provided to your office for possible completion and submission in the office's sole discretion. STELARA withMe also actively monitors the status of prior authorization submission to the patient's plan and provides status updates to your office with respect to this patient's prior authorization for treatment with STELARA®.

☐ **I do NOT wish to receive Prior Authorization Form Assistance or Status Monitoring. This opt-out does not apply if you are requesting the patient to be signed up to receive this product at no cost until their insurance covers the medication if delayed >5 business days or denied.**
☐ **Prior Authorization is already on file with the patient's plan for treatment with STELARA® IV.**
☐ **Prior Authorization is already on file with the patient's plan for treatment with subcutaneous STELARA®.**

▼ COMPLETE IF REQUESTING BENEFITS INVESTIGATION FOR INDUCTION DOSE ▼

7. Single IV Induction Information

Please Investigate ☐ **Pharmacy & Medical Benefits**

DATE OF INFUSION INDUCTION DOSE (Required) _____

Patient Weight _____ lb _____ kg

☐ 55 kg or less — 260 mg (2 x 130 mg/26 mL vials) at Week 0
☐ more than 55 kg to 85 kg — 390 mg (3 x 130 mg/26 mL vials) at Week 0
☐ more than 85 kg — 520 mg (4 x 130 mg/26 mL vials) at Week 0

SITE OF INFUSION (REQUIRED IF DIFFERENT FROM PRESCRIBER'S OFFICE)

☐ Non-prescriber's office ☐ Hospital outpatient ☐ Infusion center ☐ Other

PHYSICIAN OR INFUSION PROVIDER NAME _____

PRACTICE/FACILITY NAME _____ NPI # _____ TAX ID # _____

ADDRESS _____ CITY _____

STATE _____ ZIP CODE _____ PHONE _____ FAX _____

▼ COMPLETE IF REQUESTING BENEFITS INVESTIGATION FOR MAINTENANCE DOSE ▼

8. Maintenance Dose Information

Please investigate ☐ **Pharmacy & Medical Benefits** ☐ **90 mg/mL single-use prefilled syringe** ☐ **45 mg/0.5 mL vials**

SHIPPING INFORMATION FOR MAINTENANCE THERAPY (Required to complete benefits investigation even if not prescribing. NOTE: Shipments cannot be sent to P.O. Boxes)

SHIP TO: ☐ Office ☐ Patient (Payer may require pharmacy benefit use only if selected) ☐ Hospital outpatient ☐ Other

ADDRESS _____ CITY _____

STATE _____ ZIP CODE _____ PHONE _____ FAX _____

Rx STELARA® MAINTENANCE THERAPY (Do not complete this section if requesting benefits investigation only.)

DATE OF INFUSION INDUCTION DOSE (If known) _____

☐ 1 single-use prefilled syringe; **90 mg** SC every 8 weeks Refills # _____

☐ Two 45 mg vials; **90 mg** SC every 8 weeks Refills # _____

Preferred Specialty Pharmacy (Optional) _____

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

Delay and Denial Support

When commercial insurance coverage is delayed >5 business days or denied, STELARA withMe offers eligible patients STELARA® **at no cost** until their commercial insurance covers the medication. By enrolling the patient for this support, I certify that I agree to the program requirements and will take any necessary action described in the requirements for my patient. **See program requirements on the next page.**

PRESCRIBER SIGNATURE (Dispense as written) _____ DATE _____

Please read the full Prescribing Information and Medication Guide for STELARA® and discuss any questions you have with your doctor.

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Information about your patient's insurance coverage, cost support options, and treatment support is given by service providers for STELARA withMe via Janssen CarePath. The information you get does not require you or your patient to use any Janssen product. Because the information we give you comes from outside sources, STELARA withMe cannot promise the information will be complete. STELARA withMe cost support is not for patients in the Johnson & Johnson Patient Assistance Foundation.

STELARA withMe Delay and Denial Support

STELARA withMe offers eligible patients subcutaneous STELARA® (ustekinumab) **at no cost** until their commercial insurance covers the medication. See program requirements below.

To be eligible, patient must have:

1. a subcutaneous STELARA® prescription for an on-label, FDA-approved indication
2. commercial insurance with biologics coverage
3. a delay of more than 5 business days or a denial of treatment from their insurance.

In addition, for patient to be eligible, Prescriber must submit:

4. a program enrollment form*
5. a coverage determination form (ie, prior authorization or prior authorization with exception) to the commercial insurance. If coverage is denied, Prescriber must also submit a Letter of Formulary Exception, Letter of Medical Necessity, or appeal within 90 days of patient becoming eligible for patient to stay in the program.

Patient is not eligible if:

1. patient uses any state or federal government-funded healthcare program to cover medication costs. Examples of these programs are Medicare, Medicaid, TRICARE, Department of Defense, and Veterans Administration
2. prior authorization is denied due to missing information on coverage determination form, use for a non-FDA-approved indication, or invalid clinical rationale.

Patient is eligible until commercial insurance covers the medication. Program requires periodic verification of insurance coverage status to confirm continued eligibility.

Program covers the cost of therapy only—not associated administration cost. Prescriber cannot bill commercial insurance plan for any part of the prescribed subcutaneous treatment. Patient cannot submit the value of the free product as a claim for payment to any health plan. Program good only in the United States and its territories. Void where prohibited, taxed, or limited by law. Program terms may change.

Participating prescribers authorize STELARA withMe to:

1. conduct a benefits investigation and confirm prior authorization requirements
2. provide prior authorization form assistance and status monitoring, including the exceptions and appeals processes
3. refer eligible patients to Wegmans Specialty Pharmacy for further program support and shipment of medication
4. support the transition of patients to commercial product if the medication is covered
5. check insurance coverage status during the program.

*STELARA withMe cannot accept any information without an executed Janssen CarePath Business Associate Agreement and/or Patient Authorization on file. The Patient Authorization can be found on this Prescription Information and Enrollment Form.

Please read the full Prescribing Information and Medication Guide for STELARA® and discuss any questions you have with your doctor.

Janssen
PHARMACEUTICAL COMPANIES OF
Johnson & Johnson

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 866-769-3903 or mailed to STELARA withMe, 2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560**

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.

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Janssen Patient Support Program Patient Authorization Form

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. 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: STELARA withMe, 2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560.

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:

_____

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