INSTRUCTIONS FOR ENROLLMENT

Patient Assistance Program Application

Johnson & Johnson PATIENT ASSISTANCE FOUNDATION, INC.

PATIENT CHECKLIST FOR SUBMITTING AN APPLICATION

- ☐ Read the Patient Declaration and Patient Authorization to Share Health Information on page 4, then complete all relevant patient information on page 2, and **sign and date** as required
- ☐ Include a copy of the **front and back** of your insurance card
- ☐ **Proof of income** (Choose one): Check the box in Section 4 on page 2 **OR** Include a copy of your most recent 1040 or 1040-SR Federal tax return
- ☐ Ask your Healthcare Professional (HCP) to complete, and **sign and date** page 3
- ☐ Submit completed pages **2 and 3 only** with documentation to:

Mail: Johnson & Johnson Patient Assistance Foundation, Inc.
Patient Assistance Program
PO Box 0367, Chesterfield, MO 63006

Fax: 1-888-526-5168

Missing information and/or required documents may delay processing of application.

If you have questions about Johnson & Johnson Patient Assistance Foundation, Inc. (JJPAF) or how to complete this form, please contact us at 1-800-652-6227, 9am – 6pm EST, Monday through Friday.

MEDICATIONS AVAILABLE THROUGH THE PATIENT ASSISTANCE PROGRAM

Medications shipped to the patient's residence

BALVERSA® (erdafitinib) Tablets

ERLEADA® (apalutamide) Tablets

IMBRUVICA® (ibrutinib) Capsules or Tablets

ZYTIGA® (abiraterone acetate) Tablets

Medications shipped to the HCP's office

DARZALEX® (daratumumab) Injection for intravenous infusion

DARZALEX *FASPRO*® (daratumumab and hyaluronidase-fihj), Injection for subcutaneous use

HALDOL® Decanoate* (haloperidol decanoate) Injection for extended-duration for effect

INVEGA SUSTENNA®* (paliperidone palmitate) Extended-release Injectable Suspension

INVEGA TRINZA®* (paliperidone palmitate) Extended-release Injectable Suspension

MONOVISC® (high molecular weight hyaluronan) Injection

ORTHOVISC® (high molecular weight hyaluronan) Injection

REMICADE®* (infliximab) Intravenous Infusion

RISPERDAL CONSTA®* (risperidone) Long-acting Injection

RYBREVANT™ (amivantamab-vmjw) Injection, for intravenous use

SIMPONI ARIA®* (golimumab) Intravenous Infusion

STELARA®† (ustekinumab) Injection, for subcutaneous or intravenous use

TREMFYA® (guselkumab) Prefilled syringe or One-Press patient-controlled injector

YONDELIS® (trabectedin) Injection for intravenous infusion

Medications available through retail or specialty pharmacy. HCP must provide a prescription.

CONCERTA®* (methylphenidate HCl) Extended-release Tablets CII

EDURANT® (rilpivirine) Tablets

ELMIRON® (pentosan polysulfate sodium) Capsules

INTELENCE® (etravirine) Tablets

INVOKAMET®* (canagliflozin/metformin HCl) Tablets

INVOKAMET® XR* (canagliflozin/metformin HCl) Extended-release Tablets

INVOKANA® (canagliflozin) Tablets

PONVORY™ (ponesimod) Tablets

PREZCOBIX® (darunavir 800mg/cobicistat 150mg) Tablets

PREZISTA® (darunavir) Tablets or Oral Suspension

PROCRIT®* (epoetin alfa) Injection, for subcutaneous or intravenous use

SIMPONI®* (golimumab) SmartJect® or Prefilled syringe

SIRTURO®* (bedaquiline) Tablets

SPORANOX®* (itraconazole) Capsules or Oral Solution

SPRAVATO®* (esketamine) Nasal Spray CIII, for intranasal use

STELARA®† (ustekinumab) Injection, for subcutaneous or intravenous use

SYMTUZA®* (darunavir, cobicistat, emtricitabine, and tenofovir alafenamide) Tablets

TREMFYA® (guselkumab) Prefilled syringe or One-Press patient-controlled injector

XARELTO®* (rivaroxaban) Tablets

*Please read full Prescribing Information, including Boxed Warning.
†May be distributed via pharmacy or shipped to HCP.

The Johnson & Johnson Patient Assistance Foundation, Inc. (JJPAF) is an independent, non-profit organization that is committed to helping eligible patients without insurance coverage receive prescription products donated by Johnson & Johnson operating companies.

You may be eligible for our free prescription program for up to one year if you meet the requirements below:

- You have been prescribed a Johnson & Johnson operating company donated medication
- You meet the eligibility income requirements for the medication(s)
- You don't have insurance **or** medicine is not covered
  - Some patients with Medicare Prescription Drug Coverage (Part D) who cannot afford their medicines and who meet certain financial criteria may also be eligible for assistance. A report from your pharmacy or an Explanation of Benefits (EOB) statement from your insurer that shows your out-of-pocket costs for the current year can be requested and may be submitted with your application. In order to qualify for the program, you must spend 4% or more of your gross annual income on prescription drugs.
- You live in the United States or a U.S. territory
- You are being treated by a U.S. licensed doctor as an outpatient

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Patient Assistance Program Application

Johnson & Johnson PATIENT ASSISTANCE FOUNDATION, INC.

TO BE COMPLETED BY THE PATIENT See checklist on page 1—all information is required.

1 Patient Information

Name: _____ Phone: _____ Email: _____

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

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

2 Financial Information

Federal Taxes *(Select one of the options below **ONLY** if you do not check the box in Section 4)*

☐ A copy of my most recent 1040 or 1040-SR Federal tax return is attached.
(Not required for SIRTURO® applications.)*

☐ I do not file Federal taxes.
(Tax returns may be reviewed and additional documentation requested.)

Total Gross Yearly Income
Entire household: $ _____

Household Size
Including yourself, the number of people who live in your home and are dependent on your household income: _____

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

Please provide copies of front and back of all medical and prescription insurance cards.

Subscriber Name: _____ Date of Birth: _____ Relationship to Patient: _____

Primary Plan Name: _____ Secondary Plan Name: _____

☐ Check if no insurance	ID/Policy #	Group #	Phone
☐ Prescription Insurance/Medicare Part D Plan Plan Name: _____ Fax: _____ Rx BIN #: _____ Rx PCN: _____			
☐ Private/Commercial Insurance			
☐ Medicaid			
☐ Medicare Part B			
☐ Medicare Advantage			
☐ Veterans Administration			
☐ ADAP AIDS			
☐ SPAP State Patient Assistance Program			
☐ Other:			

4 Patient Declaration/Authorization to Assign Representative for Program Enrollment

Signature and date required before submission.

My signature below indicates that I have read, understand, and agree to the Patient Declaration and Patient Authorization to Share Health Information on page 4. If I have listed an authorized representative below, I permit the Johnson & Johnson Patient Assistance Foundation, Inc. (JJPAF) to discuss my application with this person. This includes the status of my application, insurance and financial questions, any missing documentation, and other issues related to my application and participation, throughout my enrollment period in the program. By signing below, this representative is allowed to speak on my behalf regarding my application with JJPAF.

CHECK THE BOX: ☐

Applicant Financial Verification Authorization

I also understand that JJPAF and the vendors associated with administrating the Program (collectively the "Program Administrators") may obtain a credit report or investigative credit report about me which may contain information as to my income or credit standing, to determine my eligibility for the Program. I hereby authorize such credit report and income verification and acknowledge that such authorization extends to consumer reporting agencies and to subsequent reports for purposes of determining my eligibility for the JJPAF Program.

PLEASE COMPLETE, SIGN & DATE:

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

Authorized Representative Name *(print if applicable)*: _____

Relationship to Patient *(print if applicable)*: _____ Phone: _____

_____ Date: _____

Patient Signature/Authorized Representative

*Please read full Prescribing Information, including Boxed Warning.

Revised: June 2021

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Johnson & Johnson PATIENT ASSISTANCE FOUNDATION, INC.

TO BE COMPLETED BY THE HEALTHCARE PROFESSIONAL (HCP)—all information is required.

1 Prescription *(If requesting more than 1 product, attach additional prescription information.)*

Patient Name: _____ Date of Birth: _____

ICD Code *(HCP-administered products only)*: _____

Name of Product: _____

Strength: _____ Sig: _____

Quantity: _____ Days' Supply: _____ Number of Refills *(maximum 11)*: _____

BALVERSA®, ERLEADA®, IMBRUVICA®, or ZYTIGA®:

- If you are a prescriber in New York, South Carolina, or Washington and are requesting BALVERSA®, ERLEADA®, IMBRUVICA®, or ZYTIGA®, you must attach prescription on your state official prescription form with this application.

BALVERSA®, ERLEADA®, IMBRUVICA®, or ZYTIGA®:

- List any patient allergies:

_____
_____ or ☐ NKDA

BALVERSA®, ERLEADA®, IMBRUVICA®, or ZYTIGA®:

- List patient's current medications:

_____
_____ or ☐ none

BALVERSA®:

- Has the patient tested positive for FGFR? ☐ Yes ☐ No

HIV Medication:

- Check if patient is currently taking: ☐ PREZISTA® ☐ PREZCOBIX® ☐ INTELENCE® ☐ EDURANT® ☐ SYMTUZA®*

PROCRIT®*:

- Hemoglobin level based on most recent lab results: _____
- Required: Is the patient being treated on renal dialysis? ☐ Yes† ☐ No

RYBREVANT™:

- Has the patient tested positive for EGFR exon 20 insertion mutation? ☐ Yes ☐ No

Select STELARA® Distribution Option (must select one):

☐ Ship to HCP's office
☐ Retail or specialty pharmacy. HCP must provide a prescription.

Select TREMFYA® Distribution Option (must select one):

☐ Ship to HCP's office
☐ Retail or specialty pharmacy. HCP must provide a prescription.

2 HCP Information

Name: _____ Site Name: _____

Site Contact: _____ Business Hours: _____

Address *(City, State, ZIP)*: _____

Phone: _____ Fax: _____ Email: _____

Tax ID #: _____ NPI # *(required)*: _____

State License # *(required)*: _____ Expiration *(mm/yyyy)*: _____ DEA # *(required)*: _____

Collaborating MD *(for mid-level providers)*: _____ Collaborating MD NPI # *(required)*: _____

Provider Transaction Access Number (PTAN) *(required if the patient has Medicare)*: _____

HCP Distribution Shipping Address or SPRAVATO® REMS-Certified Treatment Center Address (if different from above):

Site Name: _____ Contact Name for Shipment: _____

Business Hours: _____ Phone: _____ Fax: _____

Address *(City, State, ZIP)*: _____

Please note, Florida HCPs may be required to provide Florida Pedigree information at time of first shipment.

3 HCP Authorization

My signature below indicates that I have read, understand, and agree to the Johnson & Johnson Patient Assistance Foundation, Inc. policy and the terms of Program participation on page 5.

HCP SIGN & DATE: _____ Date: _____
Healthcare Professional Signature

*Please read full Prescribing Information, including Boxed Warning.
†Contact Amgen Inc. 1-800-772-6436.

Print Form

Patient Assistance Program Application

PATIENT DECLARATION AND PATIENT AUTHORIZATION TO SHARE HEALTH INFORMATION

Please read, sign and date on page 2, Patient Section 4.

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 ("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.
- Not to attempt to claim or submit any costs associated with the medicine(s) I receive under the Johnson & Johnson Patient Assistance Foundation, Inc. Patient Assistance Program to any person or entity, including my Medicare Part D plan.
- Not to seek true out-of-pocket (TrOOP) credit under the Medicare Part D program for the cost of the medicine(s) I receive under this program.

I authorize the following communications:

- Specifically, I authorize JJPAF to contact me to request my assistance with analysis related to the quality and efficacy of the JJPAF Program.
- When signing this application, I am agreeing to allow the manufacturer or its agent to contact me or my healthcare provider for additional information, if needed, to evaluate any adverse event or product complaint I or my provider reported on my behalf.
- The Program to contact my insurer, other potential funding sources, including the Centers for Medicare and Medicaid Services, social workers, or patient advocacy organizations on my behalf in order to determine if I am eligible for health insurance coverage or other funds, and disclose to them information contained in my JJPAF Program application or information about my prescribed medications and medical condition that has been provided by my physician, healthcare provider, or pharmacist.

I understand that JJPAF and the vendors associated with administrating the Program (collectively the "Program Administrators"):

- Reserve the right without notice to change the application form, change the Program or Program criteria, or terminate my enrollment at any time, without notice.
- May request and obtain information about my or my family's income, including verification of my income through third-party sources.

Patient Authorization To Share Health Information: By signing on page 2, I hereby authorize:

- My doctor(s), pharmacy and other healthcare providers, and my health plan or insurers ("Entities") to disclose to and share with JJPAF, the Program Administrators and their affiliates, agents, contractors, representatives, service providers, and assignees ("JJPAF Recipients"), my individually identifiable health information, which may include my full name, demographic information, financial information, and information related to medical condition, treatment, care management, health insurance and benefits, medication history, and prescriptions (collectively, "Health Information"), whether in written or verbal form, including portions of my medical record.
- The JJPAF Recipients to access, obtain, use, disclose, receive, and maintain my Health Information for purposes of processing this Application, verifying the information provided in this Application, assisting in the identification of or determining eligibility under the Program and other patient assistance resources, investigating and verifying my insurance benefits, coordinating the dispensing and delivery of medication, and conducting the additional services described above and to run the Program, including internal business purposes.

In addition, by signing on page 2, I understand and agree that:

- I may refuse to sign the form on page 2. This authorization is voluntary, but if I refuse to sign this form, I know that this means that I may no longer be eligible to receive assistance from the Program. I understand that my doctor(s), pharmacy and other healthcare providers, and my health plan or insurers may not condition the provision of my treatment, or coverage of my benefits, on my signing this authorization.
- Health Information released under this authorization may no longer be protected by state and federal law, including the Health Insurance Portability and Accountability Act (HIPAA).
- The information provided in this application may be subject to random audits and verification, and that during such audits and verification processes, I may be asked for additional supporting documentation and will comply with such requests.
- I may withdraw my authorization at any time by mailing a written withdrawal to JJPAF at PO Box 0367, Chesterfield, MO 63006, however, such withdrawal will not have an impact on any actions that have already been taken in reliance on this authorization.
- This authorization will last until I am no longer participating in the Program or sooner as limited by applicable state law.
- I have a right to receive a copy of this authorization.

Patient Assistance Program Application

Johnson & Johnson PATIENT ASSISTANCE FOUNDATION, INC.

HEALTHCARE PROFESSIONAL AUTHORIZATION: JJPAF POLICY AND TERMS & CONDITIONS AGREEMENT

Please read, sign and date on page 3, HCP Section 3.

Johnson & Johnson Patient Assistance Foundation, Inc. (JJPAF) policy prohibits Healthcare Professionals (HCPs) from charging patients any fee for enrollment or other activities associated solely with the patient's participation in the Patient Assistance Program ("Program").

- JJPAF requests that HCPs 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.
- In accordance with the CMS Medicare Policy Manual, CMS will not reimburse you for any free product donated from JJPAF. In addition, in accordance with our eligibility criteria, Medicare Part B patients may receive free physician-administered product from JJPAF when such product is not covered by CMS. In such a case, and according to CMS policy, claims for administration services may not be reimbursed. You accept product from JJPAF with this understanding.
- The products(s) provided under the Program may not be sold or traded and may not be returned for credit.
- The JJPAF Program is limited to patients being treated on an outpatient basis.
- JJPAF and the vendors associated with administrating the Program (collectively, the "Program Administrators") reserve the right to request additional information if needed and to change or terminate the Program at any time, without notice.
- JJPAF and the Program Administrators reserve the right to refuse to distribute the medications under this program to any patient or facility at any time, without notice.

Indicate your agreement to the terms of the JJPAF Program participation by signing on page 3. Your signature is intended to confirm to JJPAF:

- There is a valid medical need for this patient's prescription.
- I authorize JJPAF or its affiliated companies or subcontractors to forward the patient's prescription to a dispensing pharmacy on behalf of the patient.
- I authorize JJPAF to use my provider information, including National Provider ID # to determine a patient's eligibility in the Program.
- That to the best of your knowledge this patient does not have prescription drug insurance coverage for the product(s) listed above.
- For SIRTURO®*, if the patient has been diagnosed with pulmonary multi-drug resistant tuberculosis (MDR-TB), appropriate notification has been made to the local (state) health department.
- For SPRAVATO®*, the healthcare setting will be certified in the SPRAVATO® Risk Evaluation and Mitigation Strategy (REMS) and the patient will be enrolled in the SPRAVATO® REMS. SPRAVATO® will not be dispensed directly to this patient for home use.
- You are not prohibited from participating in Federally funded healthcare programs nor are you on the List of Excluded Individuals/Entities maintained by the HHS Office of Inspector General.
- That the medication(s) provided to you by the Program will not be provided or dispensed to any other person.
- I have a signed copy on file of my patient's current and completed patient authorization to share health information in accordance with HIPAA, or any other authorization or consent required by law, so that you may share patient health information with the Program, including the JJPAF Recipients.
- I understand that the information provided in this application may be subject to random audits and verification and that, during such audits and verification processes, I may be asked for additional supporting documentation and will comply with such requests.