FLEXCARE SPECIALTY SERVICES

Thank you for your referral for **STELARA**

(for Dermatology indications).

REQUIRED DOCUMENTATION

Please send the following items to initiate the new prescription process:

- ☑ Manufacturer form (attached), complete with FlexCare Specialty Services identified as the preferred specialty pharmacy
- ☑ Patient Demographics
- ☑ Insurance Card
- ☑ Recent Clinicals & Labs
- ☑ Medication List
- ☑ Tried/Failed Therapies
- ☑ Negative TB Results

INSTRUCTIONS

1. Please send the completed forms to us for processing.
2. You may also send the completed forms to the manufacturer, if enrollment into the manufacturer's monitoring program is desired.

PHONE: 866-205-4239 | FAX: 855-222-2514
Email: referrals@flexcarespecialty.com | visit: flexcareinfusion.com/referrals

Stelara withMe | Stelara® (ustekinumab)

Benefits Investigation and Prescription Form

UPDATE 09.22

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 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)

FIRST NAME _____ LAST NAME _____ DOB (MM/DD/YYYY) _____ GENDER _____

ADDRESS _____ CITY _____

STATE _____ ZIP CODE _____ PHONE _____ EMAIL _____

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

MEDICAL INSURANCE (MI) _____ MI POLICY# _____ MI GROUP# _____

MI CARDHOLDER FIRST NAME _____ MI CARDHOLDER LAST NAME _____

MI DOB (MM/DD/YYYY) _____ RELATIONSHIP TO CARDHOLDER _____

PHARMACY INSURANCE (Rx) _____ Rx PCN# _____ Rx GROUP# _____

Rx CARDHOLDER FIRST NAME _____ Rx CARDHOLDER LAST NAME _____

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

SECONDARY INSURANCE (SI) _____ SI POLICY# _____ SI GROUP# _____

SI CARDHOLDER FIRST NAME _____ SI CARDHOLDER LAST NAME _____ SI DOB (MM/DD/YY YY) _____

▼ TO BE COMPLETED BY PROVIDER ▼

3. Prescriber Information (Required)

PRESCRIBER FIRST NAME _____ PRESCRIBER LAST NAME _____

OFFICE CONTACT FIRST NAME _____ OFFICE CONTACT LAST NAME _____

PRACTICE NAME _____ PRACTICE TAX ID# _____ PRACTICE NPI# _____

OFFICE ADDRESS _____ OFFICE CITY _____

OFFICE STATE _____ OFFICE ZIP CODE _____ OFFICE PHONE _____ OFFICE FAX _____

4. Clinical Information (Required. This information requested is for benefits investigation purposes only.)

PRIMARY DIAGNOSIS:

PSORIASIS

- ☐ L40.0 (Psoriasis vulgaris)
- ☐ Other ICD-10 Code _____

PSORIATIC ARTHROPATHY

- ☐ L40.50 (Arthropathic psoriasis, unspecified)
- ☐ L40.51 (Distal interphalangeal psoriatic arthropathy)
- ☐ L40.52 (Psoriatic arthritis mutilans)
- ☐ L40.53 (Psoriatic spondylitis)
- ☐ L.40.54 (Psoriatic juvenile arthropathy)
- ☐ L40.59 (Other psoriatic arthropathy)
- ☐ Other ICD-10 Code _____

SECONDARY DIAGNOSIS: ICD-10 CODE _____

TB TEST DATE _____ DATE OF DIAGNOSIS OR YEARS WITH DISEASE _____

PATIENT WEIGHT _____ lb _____ kg % BSA AFFECTED _____

PRIOR MEDICATIONS (REQUIRED TO COMPLETE PRIOR AUTHORIZATION)

☐ Arava® ☐ Corticosteroids ☐ Cosentyx® ☐ Cyclosporine ☐ Enbrel® ☐ Humira® ☐ Methotrexate ☐ Otezla® ☐ Phototherapy
☐ Skyrizi® ☐ Soriatane® ☐ Taltz® ☐ Tremfya® ☐ Xeljanz® ☐ None ☐ Other _____

▼ TO BE COMPLETED BY PROVIDER ▼

5. 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 when the patient is 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 subcutaneous STELARA®.**

▼ COMPLETE IF REQUESTING BENEFITS INVESTIGATION ▼

6. Benefits Investigation (For benefits investigation only. Do not prescribe these products together.)

I would like to request a benefits investigation for STELARA® (ustekinumab).

☐ 1 single-dose 45 mg prefilled syringe ☐ 1 single-dose 90 mg prefilled syringe
☐ 1 single-dose 45 mg vial ☐ 2 single-dose 45 mg vials

I would also like to request a benefits investigation for TREMFYA® (guselkumab) which is approved for adult patients only. (Pharmacy Insurance information must be provided.)

☐ 1 single-dose 100 mg One-Press patient-controlled injector ☐ 1 single-dose 100 mg prefilled syringe

SITE OF CARE ☐ Prescribing Physician's Office ☐ Non-prescribing Physician's Office ☐ Hospital Outpatient ☐ Other

(Required if different from prescriber)

PHYSICIAN FIRST NAME _____ PHYSICIAN LAST NAME _____

CONTACT FIRST NAME _____ CONTACT LAST NAME _____

SITE NAME _____ SITE PTAN# _____

SITE NPI# _____ SITE TAX ID# _____

SITE ADDRESS _____ SITE CITY _____

SITE STATE _____ SITE ZIP CODE _____ SITE PHONE _____ SITE FAX _____

▼ IF REQUESTING BENEFITS INVESTIGATION ONLY, DO NOT COMPLETE THIS SECTION ▼

7. Prescription Information

STELARA® Rx DIRECTIONS (Select all that apply.)

VIAL STARTER DOSE for plaque psoriasis and active psoriatic arthritis (ages 6-17) weighing less than 60 kg

☐ 1 single-dose 45 mg vial at ☐ Week 0 ☐ Week 4

PREFILLED SYRINGE STARTER DOSE

☐ 1 single-dose 45 mg SC prefilled syringe ☐ Week 0 ☐ Week 4
☐ 1 single-dose 90 mg SC prefilled syringe ☐ Week 0 ☐ Week 4

VIAL MAINTENANCE THERAPY for plaque psoriasis and active psoriatic arthritis (ages 6-17) weighing less than 60 kg

☐ 1 single-dose 45 mg vial every 12 weeks Refills #_____

PREFILLED SYRINGE MAINTENANCE THERAPY

☐ 1 single-dose 45 mg SC prefilled syringe every 12 weeks Refills #_____
☐ 1 single-dose 90 mg SC prefilled syringe every 12 weeks Refills #_____

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 subcutaneous STELARA® **at no cost** until their commercial insurance covers the medication. See the program requirements on page 4. By enrolling patients in STELARA withMe Delay and Denial Support, I certify that I agree to the program requirements and will take any necessary action described in the requirements for my patient.

PRESCRIBER SIGNATURE (DISPENSE AS WRITTEN) _____ DATE _____

Please see accompanying full Prescribing Information and Medication Guides for STELARA® and TREMFYA®. Provide Medication Guides to your patients and encourage discussion.

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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.

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:

_____

janssen

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