FLEXCARE SPECIALTY SERVICES

Thank you for your referral for **TREMFYA**

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.

Notice: This message and any attached documents may contain confidential and privileged information and/or protected health information ("PHI") from the sender for the use of the recipient listed above. If you are not the intended recipient, you may not read, copy, distribute, disclose or use this communication or the information contained within it. If you have received this communication in error, please notify the sender immediately and destroy the material in its entirety, whether in electronic or hard copy format. All PHI is confidential and subject to HIPAA laws and regulations.

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

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 844-322-9402 or mailed to TREMFYA withMe, 2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560**
- **You may be able to eSign a digital Form in your healthcare provider's office or on the Janssen CarePath Patient Account at MyJanssenCarePath.com**

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

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Clear Form Print Form

Janssen Patient Support Program
Patient Authorization Form

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.

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 my Healthcare Providers may be paid by Janssen for sharing my Protected Health Information with Janssen 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: TREMFYA 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: _____ **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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Tremfya withMe | Tremfya® (guselkumab)

UPDATE 07.22

Enrollment and Prescription Form

Complete and fax this form to **844-322-9402** or mail to 2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560
For assistance, call 844-4-withMe (844-494-8463), Monday–Friday, 8:00 AM–8:00 PM ET

TREMFYA withMe cannot accept any information without an executed Janssen CarePath Business Associate Agreement or Patient Authorization Form, which can be found on pages 3 and 4 of this document.

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 TREMFYA 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.

1. PATIENT INFORMATION (REQUIRED)

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

PATIENT CELL PHONE _____ ALTERNATE PHONE _____ PATIENT E-MAIL _____

PATIENT ADDRESS _____ PATIENT CITY _____ PATIENT STATE _____ PATIENT ZIP CODE _____

2. INSURANCE INFORMATION (REQUIRED. Please fill out this section in its entirety and provide a copy of the front and back of the pharmacy insurance card.)

PHARMACY INSURANCE (Rx) _____ INSURANCE PROVIDER PHONE _____

Rx GROUP # _____ Rx ID # _____ Rx BIN # _____ Rx PCN # _____

Rx CARDHOLDER FIRST NAME _____ Rx CARDHOLDER LAST NAME _____ Rx RELATIONSHIP TO PATIENT _____

Failure to provide this information may result in delay of the benefits investigation.

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

MI CARDHOLDER FIRST NAME _____ MI CARDHOLDER LAST NAME _____ MI RELATIONSHIP TO PATIENT _____

3. PRESCRIBER INFORMATION (REQUIRED)

PRESCRIBER FIRST NAME _____ PRESCRIBER LAST NAME _____ NPI # _____ TAX ID # _____

OFFICE NAME _____ OFFICE CONTACT FIRST NAME _____ OFFICE CONTACT LAST NAME _____

PTAN # _____ OFFICE PHONE _____ OFFICE FAX _____

OFFICE ADDRESS _____ OFFICE CITY _____ OFFICE STATE _____ OFFICE ZIP CODE _____

4. CLINICAL INFORMATION (REQUIRED. Information requested is for benefits investigation purposes only.)

PRIMARY DIAGNOSIS (select one):

PSORIASIS ☐ L40.0 ☐ Other ICD-10 Code: _____

ACTIVE PSORIATIC ARTHRITIS ☐ L40.50 ☐ Other ICD-10 Code: _____

DATE OF DIAGNOSIS OR YEARS WITH DISEASE: _____

SECONDARY DIAGNOSIS (if any): _____

ICD-10 Code: _____

PRIOR THERAPIES:

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

5. PRIOR AUTHORIZATION

Prior Authorization Form Assistance and Status Monitoring: TREMFYA withMe assists your office in providing the requirements of the patient's health plan related to prior authorization for treatment with TREMFYA®. 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. TREMFYA 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 TREMFYA®.

☑ **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 the product at no cost until their insurance covers the medication if delayed >5 days or denied.**

☐ **Prior Authorization is already on file with the patient's plan for treatment with TREMFYA®.**

6. PRESCRIPTION INFORMATION

Rx DIRECTIONS

STARTER DOSE:

☐ Single-dose One-Press patient-controlled injector 100 mg/mL SC at ☐ Week 0 ☐ Week 4
(NDC: 57894-640-11)

☐ Single-dose prefilled syringe 100 mg/mL SC at ☐ Week 0 ☐ Week 4
(NDC: 57894-640-01)

MAINTENANCE THERAPY:

☐ Single-dose One-Press patient-controlled injector; 100 mg/mL SC every 8 weeks Refills # _____

☐ Single-dose prefilled syringe; 100 mg/mL SC every 8 weeks Refills # _____

PRESCRIBER SIGNATURE REQUIRED (NO STAMPS ALLOWED) TO VALIDATE PRESCRIPTION: I certify that therapy with TREMFYA® is medically necessary for this patient. I will be supervising the patient's treatment accordingly, and I have reviewed the current TREMFYA® full Prescribing Information. I authorize TREMFYA 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, TREMFYA withMe offers eligible patients TREMFYA® 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 see full Prescribing Information and Medication Guide for TREMFYA®. Provide the Medication Guide to your patients and encourage discussion.

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