

Johnson & Johnson Patient Assistance Program

Patient Enrollment Form

Instructions for Enrollment

Johnson & Johnson believes that access and affordability challenges shouldn't stand in the way of patients and their medicines. Medicines from J&J may be provided at no cost to eligible patients who are uninsured or have inadequate coverage through commercial, employer group, or government insurance coverage and are not supported by other J&J offerings.

Enrollment Checklist

- ☐ Complete all sections and sign on page 2

Review pages 4-6, which contain the Patient Consent Form and Patient Authorization Form, in their entirety. Please certify that you have read, understand, and agree by signing sections 4 and 5 on page 2.

You can also submit the Patient Consent Form and Patient Authorization Form online at:

- Patient Consent Form: [JJPatientAssistance.com/Consent](https://www.jjpatientassistance.com/Consent)
- Patient Authorization Form: [JJPatientAssistance.com/PA](https://www.jjpatientassistance.com/PA)

If you have already completed a Patient Consent Form and Patient Authorization Form, you do not need to sign new forms.

- ☐ Ask your Healthcare Provider to complete and sign page 3 (**complete a copy of page 3 for each medicine**)
- ☐ Gather any required supporting documents to determine what documents you need to include (if any)

Supporting Documents

Best practice to include if you have the following:

- ☐ Insurance Information: copies of the front and back of all insurance card(s) (eg, medical, pharmacy, etc, if you did not complete section 2 on page 2)
- ☐ Insurance denial: If your insurance denied coverage for the requested medicine, include denial documentation
- ☐ Proof of income: a copy of your most recent 1040 or 1040-SR Federal tax return
- ☐ For Puerto Rico Only: Please include financial documentation support with application submission. Acceptable forms Income Tax Return (Form 482) Form AS 6088.1 – Returns Filing Certification Form SSA-1099 – Social Security Benefits

Complete this Patient Assistance Enrollment Form to the best of your ability, including the supporting documents and fax to: 855-998-4422. Any required information you did not provide with your initial submission will cause delays in processing your application. For assistance on how to complete the form or questions about the program, call **833-742-0791**, Monday through Friday, 8:00 AM to 8:00 PM ET.

Medicines Available Through This Form

AKEEGA®* (niraparib and abiraterone acetate) Tablets, for oral use

BALVERSA®* (erdafitinib) Tablets, for oral use

DARZALEX®* (daratumumab) Injection, for intravenous infusion

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

ERLEADA®* (apalutamide) Tablets, for oral use

INLEXZO™* (gemcitabine intravesical system) Intravesical delivery system

RYBREVA™* (amivantamab-vmjw) Intravenous infusion

RYBREVA FASPRO™* (amivantamab and hyaluronidase-lpuj) Injection, for subcutaneous use

RYBREVA™* Intravenous infusion in combination with **LAZCLUZE®*** (lazertinib) Tablets

RYBREVA FASPRO®* Injection, for subcutaneous use in combination with **LAZCLUZE®*** Tablets

TALVEY®† (talquetamab-tgvs) Injection, for subcutaneous use

TECVAYLI®† (teclistamab-cqyv) Injection, for subcutaneous use

*Please read Important Safety Information and full Prescribing Information available at [JNJwithMe.com](https://www.jnjwithme.com) and available from your J&J representative.

†Please read Important Safety Information, including Boxed Warning(s), and full Prescribing Information available at [JNJwithMe.com](https://www.jnjwithme.com) and available from your J&J representative. Provide the appropriate Medication Guide to your patients and encourage discussion.

Patient Assistance Enrollment Form

The information you provide will be used by Johnson & Johnson Health Care Systems Inc., our affiliates, and our service providers to determine your eligibility for and enroll you in the Johnson & Johnson Patient Assistance Program. You may withdraw your request for these services by calling 833-565-9631. Our **Privacy Statement** further governs the use of the information you provide.

To Be Completed by Patient

Fields marked with an (*) are required

1. PATIENT INFORMATION

*First Name: _____ *Last Name: _____
Preferred Language: ☐ English ☐ Spanish ☐ Other _____ *Home Phone: _____ *Mobile Phone: _____
Email: _____ *Date of Birth (mm/dd/yyyy): _____ *Sex: _____
*Address: _____
*City: _____ *State: _____ *ZIP Code: _____
*Product Name: _____

This is the address that all self-administered medicine will be shipped to. For a change of address, please contact 833-742-0791 and share the information with your Healthcare Provider.

2. INSURANCE INFORMATION *(Complete for all available insurance and submit copies of front and back of all insurance cards.)*

☐ I have no insurance and have checked eligibility requirements or applied to all available options for free or minimal cost insurance or other assistance. If you were previously enrolled in a patient assistance program, please provide your patient ID #: _____

Primary Medical Insurance _____ Phone _____

Cardholder Name (First, MI, Last) _____ Relationship to Cardholder _____

Policy # _____ Group # _____ Fax _____

Secondary Medical Insurance _____ Phone: _____

Cardholder Name (First, MI, Last) _____ Relationship to Cardholder _____

Policy # _____ Group # _____ Fax _____

*Address Line 1 _____ Address Line 2 _____

*City _____ *State _____ *ZIP _____

3. FINANCIAL INFORMATION

*Total Gross Annual Income

Entire household: \$ _____

*Household Size

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

(A credit check is required to confirm you meet the income eligibility. This will not impact your credit score.)

4. PATIENT CONSENT FORM *(Please review Patient Consent Form on pages 4-5.)*

My signature below certifies that I have provided accurate and complete information and that I have read, understood, and agree to the Patient Consent Form on pages 4-5. Your signature also allows Johnson & Johnson to perform a credit check. This will not impact your credit score.

*Print Patient Name: _____

*Patient or legally authorized representative[†] sign here: _____ *Date: _____

[†]A Legally Authorized Representative is a person authorized, under state or other applicable law, to act on behalf of the individual in making healthcare-related decisions, such as a parent, guardian, or (court-appointed) representative.

5. PATIENT AUTHORIZATION FORM CONSENT *(Please review Patient Authorization Form on page 6.)*

By signing below, I certify that I have read, understand, and agree to the Johnson & Johnson patient support program patient authorization form on page 6.

*Print Patient Name: _____

*Patient or legally authorized representative[†] sign here: _____ *Date: _____

[†]A Legally Authorized Representative is a person authorized, under state or other applicable law, to act on behalf of the individual in making healthcare-related decisions, such as a parent, guardian, or (court-appointed) representative.

*Describe relationship to patient and authority to make medical decisions for patient: _____

6. OPTIONAL COMMUNICATIONS

Permission for communications outside of Johnson & Johnson's patient support programs:

- ☐ Yes, I would like to receive communications relating to my medicine from J&J.
☐ Yes, I would like to receive communications relating to other products and services from J&J.

Permission for text communications:

- ☐ Yes, I would like to receive text messages about the Program, including refill reminders and Rx notifications, 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 Program or to receive any other communications I have selected. Cell Phone Number: _____

For privacy rights and choices specific to California, Colorado, Connecticut, Utah, Virginia, and Washington residents, please see J&J's US Supplemental Privacy Notice available at JNJ.com/privacy-center/en-us/privacy-statement

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To Be Completed by Provider

Fields marked with an (*) are required

1. PRESCRIPTION *(Please complete a copy of this page for each medicine and dosage strength you are requesting.)*

*Patient First Name: _____ *Patient Last Name: _____ *Patient Primary Phone: _____
*Patient Address Line 1: _____ Patient Address Line 2: _____
*Patient City: _____ *Patient State: _____ *Patient ZIP Code: _____
*Patient Date of Birth (mm/dd/yyyy): _____ Patient Weight: _____ lb _____ kg *Patient Sex: _____
*ICD Code: _____ *Name of Product: _____ *Strength: _____
*Sig (Directions for use): _____
*Quantity: _____ *Day Supply: _____ *Number of Refills (maximum 11): _____ *Need by Date: _____ First Time Fill: ☐ Yes ☐ No
Additional Notes: _____

*Ship to Location:

☐ Patient Home (same as above) ☐ Prescriber Office (same as section 2. HCP Information) ☐ Treatment Center (if different from Prescriber Office)

Site Name: _____ Site Contact Name for Shipment: _____
Site Business Hours: _____ Site Phone: _____ Site Fax: _____
Site Address Line 1: _____ Site Address Line 2: _____
Site City: _____ Site State: _____ Site ZIP Code: _____

*Patient Allergies: _____ or ☐ None

*List of Patient's Current Medicines: _____ or ☐ None

For a patient prescribed more than one J&J medicine: Complete a copy of this page for each medicine.

Please note: LAZCLUZE (lazertinib) can only be prescribed in combination with RYBREVANT FASPRO (amivantamab and hyaluronidase-lpuj) or RYBREVANT (amivantamab-vmjw).

2. HCP INFORMATION *(The address you provide here will be used to ship HCP-administered medicines. Self-administered medicines will be shipped directly to the Patient.)*

*HCP First Name: _____ *HCP Last Name: _____ *HCP Site Name: _____
HCP Site Contact: _____ PTAN (Medicare patients only): _____
*HCP Address Line 1: _____
*HCP City: _____ *HCP State: _____ *HCP ZIP Code: _____
*HCP Phone: _____ *HCP Fax: _____ HCP Email: _____
*HCP Tax ID #: _____ *HCP NPI #: _____
HCP State License #: _____
*HCP Collaborating MD (for mid-level providers): _____ HCP Collaborating MD NPI #: _____
HCP Provider Transaction Access Number (PTAN) (required if the patient has Medicare): _____

If you are aware of an Assistance Diversion Program (ADP) being part of the patient's plan design, please provide the details below:

ADP Name: _____ ADP Address: _____
ADP City: _____ ADP State: _____ ADP ZIP Code: _____
ADP Phone: _____ ADP Fax: _____

3. HCP AUTHORIZATION

The prescriber is responsible for ensuring the prescription complies with their state-specific prescription requirements, such as e-prescribing, state-specific prescription form, or fax language. Noncompliance with state-specific requirements could result in outreach to the prescriber.

My signature below indicates that I have read, understand, and agree to the Johnson & Johnson Health Care Systems Inc. policy and the terms of Program participation.

**HCP SIGN
& DATE:**

*Healthcare Provider Signature _____ *HCP Authorization Date (mm/dd/yyyy): _____

Patient Consent Form

Why should I sign this form?

This form allows J&J to determine your eligibility and enroll you in the Johnson & Johnson Patient Assistance Program.

Terms of Participation

I understand that Johnson & Johnson Health Care Systems Inc. (JJHCS) and third parties associated with administrating the Program on behalf of JJHCS (collectively, the “Program Administrators”):

- Reserve the right without notice to change the application form, change the Program or Program criteria, or to terminate my enrollment at any time;
- May request and obtain information about my or my family’s income, including verification of my income, or my insurance coverage, including documentation of any insurance denials, and that the information may be requested from me, others acting on my behalf or third-party sources;
- May request that I re-verify my eligibility to receive medicines under the Program

I certify that:

- All the information on this form and all the documentation submitted are complete and correct, and to the best of my knowledge, I meet the eligibility requirements for the submission of the application
- I am completing this application voluntarily. I have not been directed by my insurance company or by a non-medical professional to complete this application. I have not been offered any financial or other benefit by any third party in order to seek assistance from Johnson & Johnson Health Care Systems Inc. (JJHCS) and I have not been told that any benefit will be denied or withheld (such as insurance coverage) if I do not complete this application
- I have completed this application myself or with the assistance of a legally authorized representative (such as a guardian), family member, caregiver, friend, healthcare provider, or representative of a patient organization. If such assistance was provided, I have reviewed the application before submission to JJHCS to ensure all information is accurate and true. No other third party has assisted with the completion of this application
- The product(s) provided under this patient assistance program will not be sold or traded
- I will notify the Johnson & Johnson Patient Assistance Program within thirty (30) days if there is any change in my income or health insurance coverage. 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
- I will not attempt to claim or submit any costs associated with the medicine(s) I receive under the Johnson & Johnson Patient Assistance Program to any person or entity, including my Medicare Part D plan
- I will not 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

Terms & Conditions

You may be eligible to receive your medicine(s) from Johnson & Johnson (J&J) at no cost for up to one year if you have been prescribed a medicine from J&J, have a financial hardship and have exhausted all other affordability options.

You must meet the eligibility and income requirements to qualify for the Johnson & Johnson Patient Assistance Program.

You are not eligible for medicine from J&J at no cost if your health insurance will cover the cost of your prescribed medicine from J&J if this application is denied. Some employers, insurers, and other companies force patients to apply for medically necessary medicines from free product programs instead of covering such medicines directly and immediately through insurance, which could lead to delays in care and discriminate against lower-income patients. These types of “Assistance Diversion Programs” are generally established by companies that profit by diverting resources away from patients in need. An Assistance Diversion Program is any insurer, employer, or third-party program that withholds coverage or payment for Patient’s medically necessary drug until Patient has completed an application for free product assistance. Assistance Diversion Programs are prohibited by J&J to make sure that help is available for patients with no safety net in place. Your insurer must submit a Patient Eligibility Certification form to confirm that your drug coverage is not subject to an Assistance Diversion Program.

The Johnson & Johnson Patient Assistance Program does not replace products that were administered or dispensed to eligible and enrolled patients from provider supply or provider-affiliated pharmacy supply.

You may not seek payment for the value of medicines from J&J received from this program from any health plan, patient assistance foundation, flexible spending account, or healthcare savings account.

Terms & Conditions (cont'd)

Before you enroll in the patient assistance program, it is important you understand that you will be asked to provide personal information that may include your name, address, phone number, email address, financial information, and/or other information, including information related to your prescription medicine insurance and treatment. This information will be used by Johnson & Johnson Health Care Systems Inc., its affiliates, and its service providers to determine your eligibility for, enroll you in, and administer the program. The use of your information will be governed by our **Privacy Statement**.

If you have Medicare Prescription Drug Coverage (Part D) and your income is equal to or less than 150% of the Federal Poverty Level (FPL), you will need to demonstrate that you are not eligible for the Low-Income Subsidy (LIS).

This program offer may not be used with any other coupon, discount, prescription savings card, free trial, or other offer. Offer good only in the United States, Puerto Rico, and the US Virgin Islands, which includes St. Thomas, St. John, and St. Croix. Void where prohibited, taxed, or limited by law. Program terms will expire at the end of each calendar year and may change or end without notice, including in specific states.

You may end your participation in the program at any time by calling 833-742-0791, Monday through Friday, 8:00 AM to 8:00 PM ET.

**Your agreement to this Patient Consent Form
is captured on page 2 section 4.**

PATIENT AUTHORIZATION FORM (“AUTHORIZATION”)

By signing below, 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 (“PHI”) as described under J&J’s support programs. My PHI includes any and all information related to my medical condition, treatment, prescriptions, health insurance coverage, and other information contained in the Patient Enrollment Form. I agree that the following entities are permitted to receive, use, and share my PHI:

- Johnson & Johnson Health Care Systems Inc., its affiliated companies, including Patient Service Center LLC, agents, and representatives (collectively “J&J”); and
- Providers of other sources of funding (including foundations and co-pay assistance providers), service providers for J&J’s support programs (including subcontractors or healthcare providers helping J&J run the program), and service providers maintaining, transmitting, de-identifying, aggregating, or analyzing data from J&J’s support programs (collectively, “Service Providers”);
- Pharmacies involved in my care; and Insurers

Also, I give permission to J&J, the Service Providers, my Healthcare Providers, and my Insurers to receive, use, and share my PHI in order to:

- see if I qualify for, sign me up for, contact me about, and provide services relating to J&J’s patient support programs, including in-home services
- communicate with my Healthcare Providers regarding access to, reimbursement for, and fulfillment of my J&J medicine, and to tell my Healthcare Provider that I am participating in a support program from J&J
- verify, assist with, and coordinate my coverage for my J&J medicine with my Insurers and Healthcare Providers
- coordinate prescription or treatment location and associated scheduling
- conduct analysis to help J&J evaluate, create, and improve its products, services, and customer support for patients prescribed J&J medicines

- share and give access to information created by J&J’s patient support programs that may be useful for my care
- communicate with me by telephone, text message, or email regarding J&J’s support programs or other J&J medicines, products, or services for the purposes set forth in the Patient Enrollment Form

I understand that J&J and the Service Providers will use reasonable efforts to keep my information private but once my PHI is disclosed as allowed on this Authorization, it may no longer be protected by federal privacy laws. I understand that I am not required to sign this Authorization. My choice about whether to sign will not change how my Healthcare Providers or Insurers treat me. If I do not sign this Authorization, or cancel or remove my permission later, I understand I will not be able to participate in or receive assistance from certain J&J support programs. I understand that pharmacies that dispense and ship my medicine and service providers for J&J’s support programs may be paid by J&J for their services and data. This may include payment for sharing PHI and other data in connection with this program, as allowed on this Authorization.

I understand I may request a copy of this Authorization. This Authorization 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 J&J’s support programs. Information collected before that date may continue to be used for the purposes set forth in this Authorization. I understand that I may cancel the permissions given by this Authorization at any time by letting J&J know in writing at: Johnson & Johnson, PO Box 15510, Pittsburgh, PA 15244. 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 J&J. I further understand that if I cancel my permission it will not affect how J&J uses and shares my PHI received by J&J prior to my cancellation.

My signature on page 2 section 5 certifies that I have read, understood, and agreed to the release of my protected health information pursuant to this Authorization.