Patient Assistance Enrollment Form – To be completed by Healthcare Provider

Completed form can be submitted:

- By your patient as part of their online enrollment at JanssenPatientAssistance.com, **OR**
- By fax to 833-512-0497

Note that this is only one part of the full application process. Please work with your patient to ensure the rest of the application is complete. Additional information can be found at NewProgramInfo.com.

The information you provide will be used by Janssen Pharmaceuticals, Inc., our affiliates, and our service providers to determine your patient's eligibility for and to enroll your patient in the program. You may withdraw your request for these services by calling 833-742-0791. Our Privacy Policy further governs the use of the information you provide.

All information is required.

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

Patient First Name: _____ Patient Last Name: _____

Date of Birth (*mm/dd/yyyy*): _____ ICD Code: _____

Name of Product: _____ Strength: _____

Sig: _____ Quantity: _____ Day Supply: _____

First Time Fill: ☐ Yes ☐ No Number of Refills (*maximum 11*): _____ Anticipated 2023 First Fill Date: _____

Patient Allergies: _____ or ☐ none

List of Patient's Current Medications: _____ or ☐ none

For SPRAVATO® (esketamine): Due to the product being a controlled substance, an Rx cannot be captured in the Patient Enrollment Form. An electronic prescription must be sent to "*Wegmans Specialty Pharmacy* #198" directly from the HCP.

For PONVORY® (ponesimod): Before initiation of treatment with PONVORY®, you are required to assess the patient's individual needs for completion of pretests. If this has been completed, please check the box below. We are unable to dispense PONVORY® for your patient until this step has been completed.

☐ I attest that I have assessed the following based on individual patient needs: Complete Blood Count, Cardiac Evaluation, Liver Function Tests, Ophthalmic Evaluation, Current or Prior Medications with Immune System Effects, and Vaccinations. This patient is cleared to initiate therapy with PONVORY®.

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

First Name: _____ Last Name: _____ Site Name: _____

Site Contact: _____ Business Hours: _____

Address Line 1: _____ Address Line 2: _____

City: _____ State: _____ ZIP Code: _____

Phone: _____ Fax: _____ Email: _____

Tax ID #: _____ NPI #: _____

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

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

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: _____ Address Line 1: _____

City: _____ State: _____ ZIP Code: _____

HCP Distribution Shipping Address for SPRAVATO® and TECVAYLI™ (teclistamab-cqyv) REMS-Certified Treatment Center Address (if different from above):

Site Name: _____ Contact Name for Shipment: _____

Business Hours: _____ Phone: _____ Fax: _____

Address Line 1: _____ Address Line 2: _____

City: _____ State: _____ ZIP Code: _____

3. HCP Authorization

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 shown on the next page.

HCP SIGN & DATE:

_____ Date (*mm/dd/yyyy*): _____

Healthcare Provider Signature

FOR ADMINISTRATIVE PURPOSES ONLY

Clear Form Print Form

Patient Assistance Enrollment Form

Terms & Conditions

PATIENT ASSISTANCE PROGRAM

You may be eligible to receive your Janssen medication(s) free of charge for up to one year if you have been prescribed a Janssen medication, have a financial hardship, and are currently enrolled in government, commercial, or employer group health insurance.

You must meet the eligibility and income requirements to qualify for the patient assistance program.

You are not eligible for free Janssen medication if your health insurance will cover the cost of your Janssen-prescribed medication if this application is denied. Some employers, insurers, and other companies force patients to apply for medically necessary medications from free product programs instead of covering such medications 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 Janssen 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.

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

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 information related to your prescription medication insurance and treatment. This information will be used by Janssen Pharmaceuticals, Inc., and its service providers to determine your eligibility for, enroll you in, and administer the program. The information will also be used to learn more about the people who use the program, to improve the program, and will be shared with service providers supporting the program.

If you have Medicare Prescription Drug Coverage (Part D) you may be asked to attest to or submit 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. To qualify for the program, 4% of your gross annual household income must be spent on out-of-pocket prescription expenses for you and/or other members of your household.

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 and its territories. 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.

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