Janssen CarePath

Patient Enrollment Guide

Completing the Patient Enrollment Form

ONCE-MONTHLY INVEGA SUSTENNA® paliperidone palmitate extended-release injectable suspension
39mg, 78mg, 117mg, 156mg, 234mg

INVEGA TRINZA® paliperidone palmitate extended-release injectable suspension
273 mg, 410 mg, 546 mg, 819 mg

RisperdalCONSTA® risperidone Long-Acting Injection
12.5mg, 25mg, 37.5mg, 50mg

Please see full Prescribing Information, including Boxed WARNING, for INVEGA SUSTENNA®, available at invegasustennahcp.com, INVEGA TRINZA®, available at invegatrinzahcp.com, and RISPERDAL CONSTA®, available at janssencns.com/risperdal.

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Prescribing Healthcare Professional (HCP) Contact Information

HCP Fax Number

- Please list accurate fax number where patient Summary of Benefits will be sent

Facility Contact(s)

- Authorized staff to relay HCP orders to Janssen CarePath

Patient Information

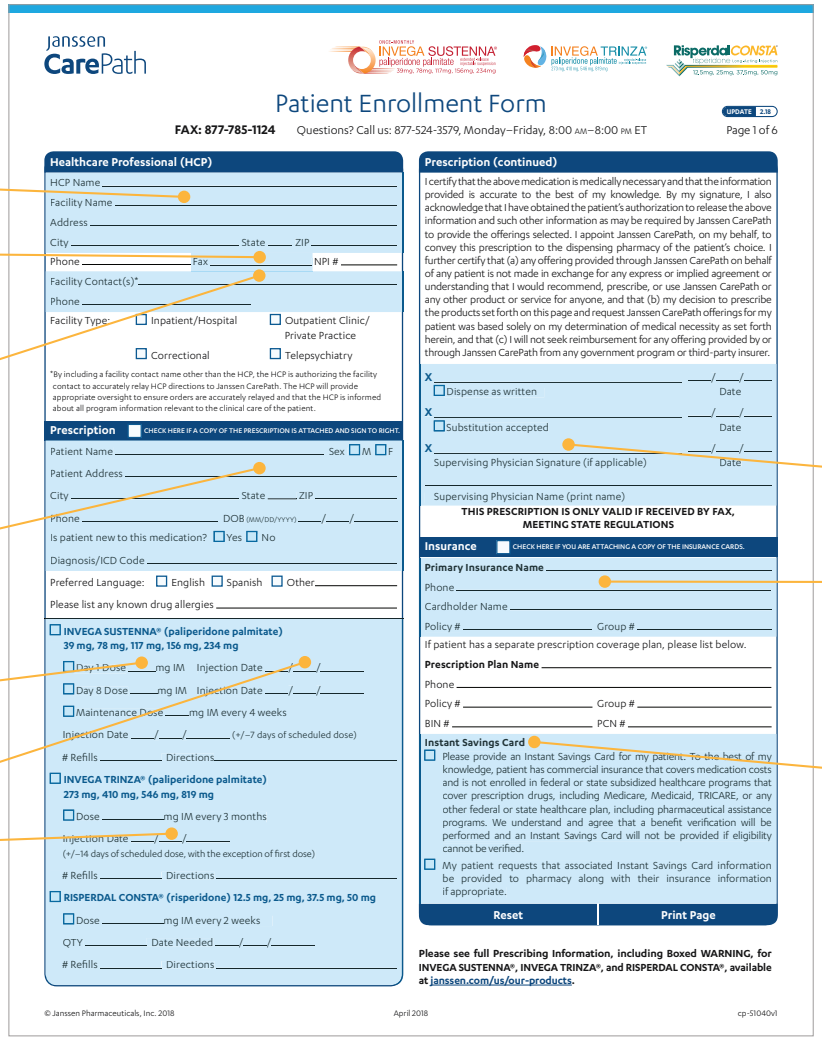
- Include diagnosis/ICD-10 code

Prescription Information

- Include drug, dose, and number of refills

Injection Date(s)

- To ensure medication to be provided on a timely basis



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UPDATE 2.18

FAX: 877-785-1124 Questions? Call us: 877-524-3579, Monday–Friday, 8:00 AM–8:00 PM ET Page 1 of 6

Healthcare Professional (HCP)

HCP Name
Facility Name
Address
City State ZIP
Phone Fax NPI #
Facility Contact(s)*
Phone
Facility Type: Inpatient/Hospital Outpatient Clinic/Private Practice Correctional Telepsychiatry

*By including a facility contact name other than the HCP, the HCP is authorizing the facility contact to accurately relay HCP directions to Janssen CarePath. The HCP will provide appropriate oversight to ensure orders are accurately relayed and that the HCP is informed about all program information relevant to the clinical care of the patient.

Prescription CHECK HERE IF A COPY OF THE PRESCRIPTION IS ATTACHED AND SIGN TO RIGHT.

Patient Name Sex M F
Patient Address
City State ZIP
Phone DOB (MM/DD/YYYY) ___/___/___
Is patient new to this medication? Yes No
Diagnosis/ICD Code
Preferred Language: English Spanish Other
Please list any known drug allergies

INVEGA SUSTENNA® (paliperidone palmitate) 39 mg, 78 mg, 117 mg, 156 mg, 234 mg
Day 1 Dose ___mg IM Injection Date ___/___/___
Day 8 Dose ___mg IM Injection Date ___/___/___
Maintenance Dose ___mg IM every 4 weeks
Injection Date ___/___/___ (+/–7 days of scheduled dose)
Refills Directions

INVEGA TRINZA® (paliperidone palmitate) 273 mg, 410 mg, 546 mg, 819 mg
Dose ___mg IM every 3 months
Injection Date ___/___/___
(+/–14 days of scheduled dose, with the exception of first dose)
Refills Directions

RISPERDAL CONSTA® (risperidone) 12.5 mg, 25 mg, 37.5 mg, 50 mg
Dose ___mg IM every 2 weeks
QTY Date Needed ___/___/___
Refills Directions

Prescription (continued)

I certify that the above medication is medically necessary and that the information provided is accurate to the best of my knowledge. By my signature, I also acknowledge that I have obtained the patient's authorization to release the above information and such other information as may be required by Janssen CarePath to provide the offerings selected. I appoint Janssen CarePath, on my behalf, to convey this prescription to the dispensing pharmacy of the patient's choice. I further certify that (a) any offering provided through Janssen CarePath on behalf of any patient is not made in exchange for any express or implied agreement or understanding that I would recommend, prescribe, or use Janssen CarePath or any other product or service for anyone, and that (b) my decision to prescribe the products set forth on this page and request Janssen CarePath offerings for my patient was based solely on my determination of medical necessity as set forth herein, and that (c) I will not seek reimbursement for any offering provided by or through Janssen CarePath from any government program or third-party insurer.

X ___/___/___
Dispense as written Date
X ___/___/___
Substitution accepted Date
X ___/___/___
Supervising Physician Signature (if applicable) Date
Supervising Physician Name (print name)

THIS PRESCRIPTION IS ONLY VALID IF RECEIVED BY FAX, MEETING STATE REGULATIONS

Insurance CHECK HERE IF YOU ARE ATTACHING A COPY OF THE INSURANCE CARDS.

Primary Insurance Name
Phone
Cardholder Name
Policy # Group #
If patient has a separate prescription coverage plan, please list below.
Prescription Plan Name
Phone
Policy # Group #
BIN # PCN #

Instant Savings Card
Please provide an Instant Savings Card for my patient. To the best of my knowledge, patient has commercial insurance that covers medication costs and is not enrolled in federal or state subsidized healthcare programs that cover prescription drugs, including Medicare, Medicaid, TRICARE, or any other federal or state healthcare plan, including pharmaceutical assistance programs. We understand and agree that a benefit verification will be performed and an Instant Savings Card will not be provided if eligibility cannot be verified.
My patient requests that associated Instant Savings Card information be provided to pharmacy along with their insurance information if appropriate.

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HCP Signature and Date Required

- Even if a prescription is attached

Insurance Information

- Include separate prescription plan (if applicable)
- Provide Phone and Policy numbers

Instant Savings Card

- Check this box for eligible patients
- Janssen CarePath will then provide this information to the patient and/or pharmacy

Important: To ensure the patient's Summary of Benefits is provided in a timely manner, please complete ALL required fields highlighted in **BLUE**

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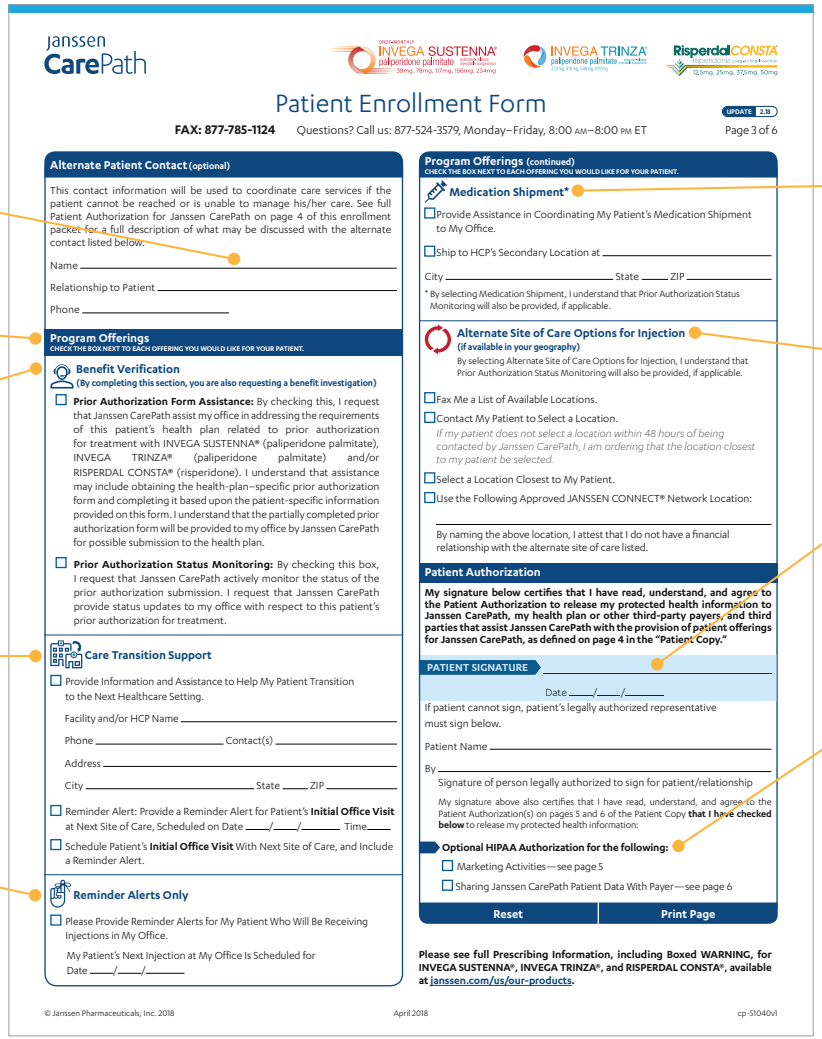
Alternate Patient Contact
- Assists with helping the patient follow HCP orders

Program Offerings
- Check box next to the offerings you are requesting

Benefit Verification
- If you require additional support, such as PA Form Assistance or PA Status Monitoring, check the appropriate box

Care Transition Support
- To help patient transition between inpatient and outpatient care settings

Reminder Alerts
- Alerts for patients receiving injections in your office
- List patient's next scheduled injection and time



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Alternate Patient Contact (optional)

This contact information will be used to coordinate care services if the patient cannot be reached or is unable to manage his/her care. See full Patient Authorization for Janssen CarePath on page 4 of this enrollment packet for a full description of what may be discussed with the alternate contact listed below.

Name _____

Relationship to Patient _____

Phone _____

Program Offerings
CHECK THE BOX NEXT TO EACH OFFERING YOU WOULD LIKE FOR YOUR PATIENT.

Benefit Verification
(By completing this section, you are also requesting a benefit investigation)

☐ **Prior Authorization Form Assistance:** By checking this, I request that Janssen CarePath assist my office in addressing the requirements of this patient's health plan related to prior authorization for treatment with INVEGA SUSTENNA® (paliperidone palmitate), INVEGA TRINZA® (paliperidone palmitate) and/or RISPERDAL CONSTA® (risperidone). I understand that assistance may include obtaining the health-plan–specific prior authorization form and completing it based upon the patient-specific information provided on this form. I understand that the partially completed prior authorization form will be provided to my office by Janssen CarePath for possible submission to the health plan.

☐ **Prior Authorization Status Monitoring:** By checking this box, I request that Janssen CarePath actively monitor the status of the prior authorization submission. I request that Janssen CarePath provide status updates to my office with respect to this patient's prior authorization for treatment.

Care Transition Support

☐ Provide Information and Assistance to Help My Patient Transition to the Next Healthcare Setting.

Facility and/or HCP Name _____

Phone _____ Contact(s) _____

Address _____

City _____ State ____ ZIP _____

☐ Reminder Alert: Provide a Reminder Alert for Patient's **Initial Office Visit** at Next Site of Care, Scheduled on Date ____/____/____ Time____

☐ Schedule Patient's **Initial Office Visit** With Next Site of Care, and Include a Reminder Alert.

Reminder Alerts Only

☐ Please Provide Reminder Alerts for My Patient Who Will Be Receiving Injections in My Office.

My Patient's Next Injection at My Office Is Scheduled for Date ____/____/____

Program Offerings (continued)
CHECK THE BOX NEXT TO EACH OFFERING YOU WOULD LIKE FOR YOUR PATIENT.

Medication Shipment*

☐ Provide Assistance in Coordinating My Patient's Medication Shipment to My Office.

☐ Ship to HCP's Secondary Location at _____

City _____ State ____ ZIP _____

* By selecting Medication Shipment, I understand that Prior Authorization Status Monitoring will also be provided, if applicable.

Alternate Site of Care Options for Injection
(if available in your geography)

By selecting Alternate Site of Care Options for Injection, I understand that Prior Authorization Status Monitoring will also be provided, if applicable.

☐ Fax Me a List of Available Locations.

☐ Contact My Patient to Select a Location.
If my patient does not select a location within 48 hours of being contacted by Janssen CarePath, I am ordering that the location closest to my patient be selected.

☐ Select a Location Closest to My Patient.

☐ Use the Following Approved JANSSEN CONNECT® Network Location:

_____

By naming the above location, I attest that I do not have a financial relationship with the alternate site of care listed.

Patient Authorization

My signature below certifies that I have read, understand, and agree to the Patient Authorization to release my protected health information to Janssen CarePath, my health plan or other third-party payers, and third parties that assist Janssen CarePath with the provision of patient offerings for Janssen CarePath, as defined on page 4 in the "Patient Copy."

PATIENT SIGNATURE _____

Date ____/____/____

If patient cannot sign, patient's legally authorized representative must sign below.

Patient Name _____

By _____

Signature of person legally authorized to sign for patient/relationship

My signature above also certifies that I have read, understand, and agree to the Patient Authorization(s) on pages 5 and 6 of the Patient Copy **that I have checked below** to release my protected health information:

Optional HIPAA Authorization for the following:

☐ Marketing Activities—see page 5

☐ Sharing Janssen CarePath Patient Data With Payer—see page 6

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Medication Shipment
- Coordinating patient medication to your office or secondary location

Alternate Site of Care Options
- Determines alternate site of care options for injections located near a patient's location*

Patient Signature and Date Required
- HIPAA authorization to share a patient's Protected Health Information

Optional HIPAA Authorizations
- Check appropriate box for Marketing Activities and/or to share Janssen CarePath patient data with payer

* Not available in all locations.

Important: A patient or patient's legal authorized representative's signature is required for Janssen CarePath Care Coordinators to review and handle protected patient health information

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Information you will receive after enrolling a patient in Janssen CarePath that outlines patient benefits and, if needed, next steps

Action Required Check Box

- If checked, there is action needed on your part to continue the patient support process
- Examples
  - Prior Authorization required
  - Alternate site of care selection
  - Patient's financial responsibility confirmation

Patient's Pharmacy Benefits

- If patient's coverage is under a pharmacy benefit, it will be listed here

Patient's Medical Benefits

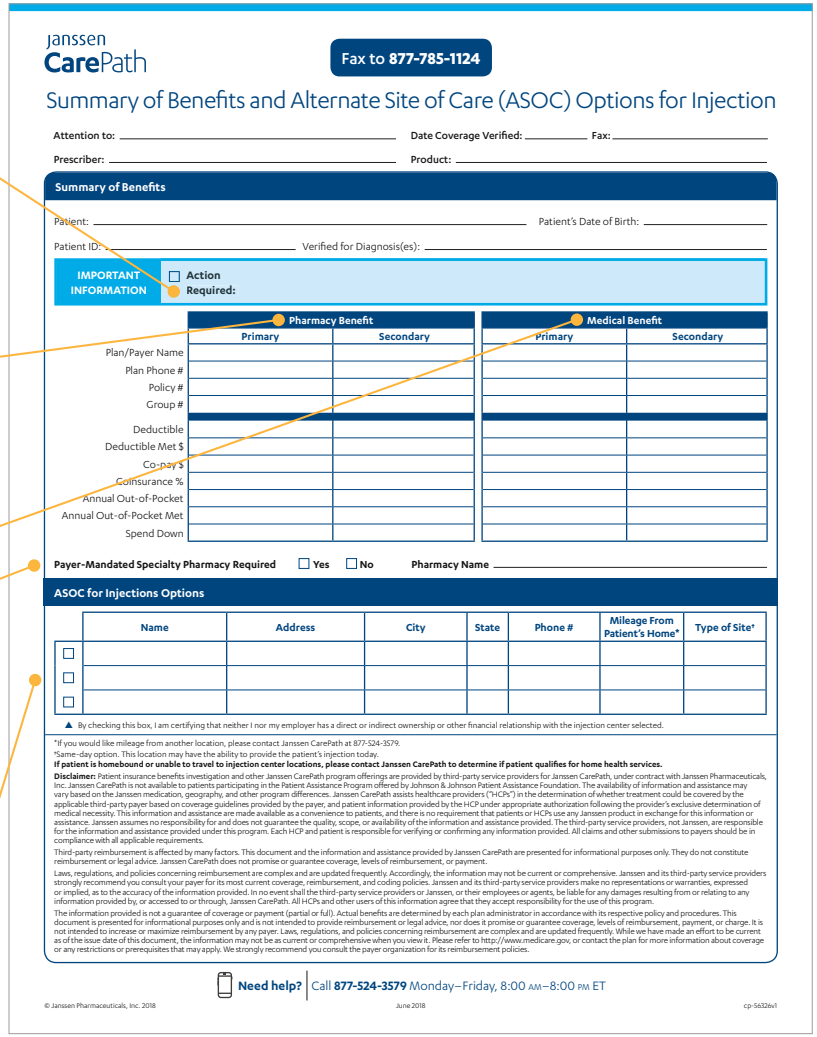
- If patient's coverage is under a medical benefit, it will be listed here
- If the plan requires Buy & Bill of the medication, it will be noted in the Important Information Box above

Payer-Mandated Specialty Pharmacy Check Box

- If YES, the patient's coverage is through a pharmacy and/or medical benefit and their plan requires their medication be filled through a contracted specialty pharmacy
- Payer-Mandated Pharmacy Name will be listed here

Alternate Site of Care Options

- If multiple locations are listed, select the preferred location and fax or call Janssen CarePath to schedule the injection*



Janssen CarePath

Fax to 877-785-1124

Summary of Benefits and Alternate Site of Care (ASOC) Options for Injection

Attention to: _____ Date Coverage Verified: _____ Fax: _____

Prescriber: _____ Product: _____

Summary of Benefits

Patient: _____ Patient's Date of Birth: _____

Patient ID: _____ Verified for Diagnosis(es): _____

IMPORTANT INFORMATION — ☐ Action Required:

	Pharmacy Benefit		Medical Benefit	
	Primary	Secondary	Primary	Secondary
Plan/Payer Name				
Plan Phone #				
Policy #				
Group #				
Deductible				
Deductible Met $				
Co-pay $				
Coinsurance %				
Annual Out-of-Pocket				
Annual Out-of-Pocket Met				
Spend Down				

Payer-Mandated Specialty Pharmacy Required ☐ Yes ☐ No Pharmacy Name _____

ASOC for Injections Options

	Name	Address	City	State	Phone #	Mileage From Patient's Home*	Type of Site†
☐							
☐							
☐							

▲ By checking this box, I am certifying that neither I nor my employer has a direct or indirect ownership or other financial relationship with the injection center selected.

*If you would like mileage from another location, please contact Janssen CarePath at 877-524-3579.
†Same-day option. This location may have the ability to provide the patient's injection today.
If patient is homebound or unable to travel to injection center locations, please contact Janssen CarePath to determine if patient qualifies for home health services.

Disclaimer: Patient insurance benefits investigation and other Janssen CarePath program offerings are provided by third-party service providers for Janssen CarePath, under contract with Janssen Pharmaceuticals, Inc. Janssen CarePath is not available to patients participating in the Patient Assistance Program offered by Johnson & Johnson Patient Assistance Foundation. The availability of information and assistance may vary based on the Janssen medication, geography, and other program differences. Janssen CarePath assists healthcare providers ("HCPs") in the determination of whether treatment could be covered by the applicable third-party payer based on coverage guidelines provided by the payer, and patient information provided by the HCP under appropriate authorization following the provider's exclusive determination of medical necessity. This information and assistance are made available as a convenience to patients, and there is no requirement that patients or HCPs use any Janssen product in exchange for this information or assistance. Janssen assumes no responsibility for and does not guarantee the quality, scope, or availability of the information and assistance provided. The third-party service providers, not Janssen, are responsible for the information and assistance provided under this program. Each HCP and patient is responsible for verifying or confirming any information provided. All claims and other submissions to payers should be in compliance with all applicable requirements.

Third-party reimbursement is affected by many factors. This document and the information and assistance provided by Janssen CarePath are presented for informational purposes only. They do not constitute reimbursement or legal advice. Janssen CarePath does not promise or guarantee coverage, levels of reimbursement, or payment.

Laws, regulations, and policies concerning reimbursement are complex and are updated frequently. Accordingly, the information may not be current or comprehensive. Janssen and its third-party service providers strongly recommend you consult your payer for its most current coverage, reimbursement, and coding policies. Janssen and its third-party service providers make no representations or warranties, expressed or implied, as to the accuracy of the information provided. In no event shall the third-party service providers or Janssen, or their employees or agents, be liable for any damages resulting from or relating to any information provided by, or accessed to or through, Janssen CarePath. All HCPs and other users of this information agree that they accept responsibility for the use of this program.

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