PATIENT ASSISTANCE PROGRAM APPLICATION
To Be Completed By Patient

Reset Button

Johnson & Johnson PATIENT ASSISTANCE FOUNDATION, INC.

To apply for assistance, please mail or fax the following items:

- **Complete Patient Page**
- **Complete Products to be Distributed Page**
- **Complete Physician Page**
- **Signed Patient Declaration and Authorization Page**
- **Copy of Patient's most recent federal tax return**

Mail to: Patient Assistance Program
PO Box 221857
Charlotte, NC 28222-1857
Telephone: 800-652-6227
Fax: 888-526-5168

PATIENT INFORMATION

Name: _____ Primary Telephone: _____

Date of Birth: _____ Social Security #: _____

Address, City, State, ZIP _____

Gender ◯ Male ◯ Female

FINANCIAL INFORMATION (All Values Should Reflect Yearly Amounts for Entire Household)

Total Gross Yearly Income $ _____ Value of Assets $ _____

Household Size: _____
(Number of people who contribute to or are dependent on your household income)

(Include: checking & savings accounts, certificates of deposit, stocks & bonds, mutual funds, IRAs, cash, and the value of life insurance policies if you turned in your policies for cash right now. **Do not include: homes, vehicles, burial plots or personal possessions.**)

Check the applicable box:

☐ **Attached is a copy of my most recent federal tax return**

☐ **I do not file federal taxes**

INSURANCE INFORMATION

Do you have any public or private insurance? ◯ Yes ◯ No

MEDICARE

Are you eligible for Medicare? ◯ Yes ◯ No

Medicare Policy # _____

Are you enrolled in a Medicare prescription drug plan? ◯ Yes ◯ No

Insurance Company: _____ Plan Name # _____

Telephone: _____ Policy ID # _____

MEDICAID

Are you eligible for Medicaid? ◯ Yes ◯ No

If "Yes", are you eligible for prescription drug benefits? ◯ Yes - Medicare Savings Program-Only (e.g., QMB, SLMB, QI-1)

◯ No - Spend-down not reached

OTHER STATE/ GOVERNMENT

Are you eligible for other state/government programs that provide prescription drug benefits (e.g., ADAP, SPAP – State Patient Assistant Program)? ◯ Yes ◯ No ◯ Applied ◯ Not Applied ◯ Application Pending ◯ Waitlist ◯ Unsure

PRIVATE/HMO

Insurance Company: _____ Telephone: _____

Policy ID # _____ Group ID # _____ Subscriber Name: _____

Does this policy cover prescription drugs? ◯ Yes ◯ No Date of Birth: _____ Relation to Patient: _____

Johnson & Johnson PATIENT ASSISTANCE FOUNDATION, INC.

Patient Name: _____

PRODUCTS TO BE DISTRIBUTED (Check all applicable)

PHARMACY CARD DISTRIBUTION - Patients receiving assistance through the Pharmacy Card will need a valid prescription from their prescribing physician to access medication.

- ☐ AXERT® Tablets (almotriptan malate)
- ☐ CONCERTA® (methylphenidate HCI) Extended-Release Tablets CII
- ☐ DITROPAN® XL (oxybutynin chloride) Extended Release Tablets
- ☐ DURAGESIC® (fentanyl transdermal system) CII
- ☐ ELMIRON® (pentosan polysulfate sodium) Capsules
- ☐ FLEXERIL® (cyclobenzaprine HC) Tablets
- ☐ LEVAQUIN® (levofloxacin) Tablets/Oral Solution
- ☐ NUCYNTA® (tapentadol) immidiate-release oral tablets C-II
- ☐ RAZADYNE® (galantamine HBr) Tablets/Oral Solution
- ☐ RAZADYNE® ER (galantamine HBr) Extended-Release Capsules
- ☐ SIMPONI™ (golimumab)
- ☐ SPORANOX® (itraconazole) Capsules
- ☐ TOPAMAX® (topiramate) Sprinkle Capsules
- ☐ TOPAMAX® (topiramate) Tablets
- ☐ ULTRACET® (tramadol hydrochloride/acetaminophen) Tablets
- ☐ ULTRAM® (tramadol hydrochloride) Tablets
- ☐ ULTRAM® ER (tramadol HCL) Extended-Release Tablets

DIRECT TO PHYSICIAN DISTRIBUTION – Medications selected for Direct to Physician Distribution will be shipped to the physician's office. Patients deemed eligible for the Program are eligible for up to 12 months of assistance as long as they continue to meet eligibility requirements.

- ☐ ACIPHEX® (rabeprazole sodium)
- ☐ BIAFINE® Topical Emulsion
- ☐ DOXIL® (doxorubicin HCL liposome injection) for intravenous infusion
- ☐ ERTACZO® (sertaconazole nitrate) Cream 2%
- ☐ GRIFULVIN V® (griseofulvin tablets) microsize Tablets
- ☐ HALDOL® (haloperidol) Injection
- ☐ HALDOL® (haloperidol) Decanoate Injection
- ☐ INVEGA® SUSTENNA® (paliperidone palmitate) Extended-Release Injectable Suspension
- ☐ LEUSTATIN® (cladribine) Injection
- ☐ NATRECOR® (nesiritide) for Injection
- ☐ ORTHOVISC® High Molecular Weight Hyaluronan
- ☐ PANCREAZE™ (pancrelipase) Delayed-Release Capsules
- ☐ PARAFON FORTE® DSC (chlorzoxazone) Caplets
- ☐ REMICADE® (infliximab) for IV Injection
- ☐ RETIN-A® (tretinoin) Cream, Gel or Micro
- ☐ RISPERDAL® CONSTA® (risperidone) Long-Acting Injection
- ☐ RISPERDAL® CONSTA® (risperidone) Long-Acting Injection with three week oral Risperdal® therapy
- ☐ SPORANOX® (itraconazole) Oral Solution
- ☐ STELARA™ (ustekinumab)
- ☐ TERAZOL® 3 (terconazole) Vaginal Cream or Suppositories
- ☐ TERAZOL® 7 (terconazole) Vaginal Cream
- ☐ UVADEX® (Methoxsalen) STERILE SOLUTION

☐ ALAMAST® (pemirolast potassium ophthalmic solution) 0.1%	Quantity 1 Bottle = 10 ml	0.1%	Number of Bottles _____
☐ BETIMOL® (timolol ophthalmic solution) 0. 5%	Quantity 1 Bottle = 5 ml	0.5%	Number of Bottles _____
☐ BETIMOL® (timolol ophthalmic solution) 0.5%	Quantity 1 Bottle = 15 ml	0.5%	Number of Bottles _____
☐ BETIMOL® (timolol ophthalmic solution) 0.25%	Quantity 1 Bottle =5 ml	0.25%	Number of Bottles _____
☐ IQUIX® (levofloxacin ophthalmic solution) 1.5%	Quantity 1 Bottle = 5 ml	1.5%	Number of Bottles _____
☐ QUIXIN® (levofloxacin ophthalmic solution) 0.5%	Quantity 1 Bottle = 5 ml	0.5%	Number of Bottles _____

PHARMACY CARD OR DIRECT TO PHYSICIAN DISTRIBUTION - Check the preferred method of distribution when selecting products below. See limitations above.

RISPERDAL® (risperidone) Tablets/ Oral Solution	☐ Pharmacy Card	or	☐ Direct to Physician
RISPERDAL® (risperidone) M-TAB® Orally Disintegrating Tablets	☐ Pharmacy Card	or	☐ Direct to Physician
INVEGA® (paliperidone) Extended-Release Tablets	☐ Pharmacy Card	or	☐ Direct to Physician
PROCRIT® (Epoetin alfa) FOR INJECTION	☐ Pharmacy Card	or	☐ Direct to Physician
PREZISTA® (darunavir) Tablets	☐ Pharmacy Card	or	☐ Direct to Physician
INTELENCE® (etravirine) Tablets	☐ Pharmacy Card	or	☐ Direct to Physician

Please check box to indicate if patient is currently on PREZISTA® ☐ or INTELENCE® ☐

Patient Name: _____

ICD-9 Code (Required for Physician Administered Products Only)
_____ ; _____

PHYSICIAN INFORMATION

Physician Name:_____ Telephone: _____ Fax: _____

Facility Name: _____ Tax ID #: _____

Office Contact Name: _____ National Provider ID #: _____

Address City, State, ZIP: _____

DIRECT TO PHYSICIAN DELIVERY ADDRESS

If the shipping address is different from the physician's address, provide the shipping address below.

Facility Name: _____ Telephone: _____ Fax: _____

Facility Contact Name: _____ Business Hours: _____

Address, City, State, ZIP: _____

PRESCRIBING INFORMATION (Attach additional prescription if more than two products are selected for Direct to Physician Distribution)

Patient Name: _____

Product #1 Name _____

Dosage: _____Sig:_____

Quantity: _____

Date: _____
Number of Refills (maximum 12): _____

Product #2 Name _____

Dosage: _____Sig: _____

Quantity: _____

Date: _____
Number of Refills (maximum 12): _____

State License # (required):
_____

Physician DEA # (required):
_____

If this patient is not currently on an oral antipsychotic medication and requires three weeks of oral RISPERDAL®, please attach prescribing information for both oral RISPERDAL® and RISPERDAL® CONSTA®. The prescription information section above may be completed for RISPERDAL® CONSTA® therapy extending beyond three weeks.

Johnson & Johnson Patient Assistance Foundation (JJPAF) policy prohibits physicians from charging the patient any fee for enrollment or other activities associated solely with the patient's participation in this patient assistance program (Program). JJPAF requests that physicians not charge the patient for those professional services associated with this regimen not covered by the patient's health insurer. No claim may be made to any third party payer (e.g., Medicaid, Medicare, private insurance, etc.) for payment for product provided under the Program. The product(s) provided under this patient assistance program may not be sold or traded and may not be returned for credit. Please indicate your agreement to the terms of Program participation by signing below. In addition, your signature is intended to confirm to JJPAF that: (1) there is a valid medical need for this patient's prescription; (2) that to the best of your knowledge this patient does not have prescription drug insurance coverage (including Medicare, Medicaid, county funded, or other public programs) for the product(s) listed above; and (3) you are not prohibited from participating in Federally-funded health care programs nor are you on the List of Excluded Individuals/Entities maintained by the HHS Office of Inspector General.

Physician Signature: **Date:**

Patient Declaration

I promise:

- The information on this form is correct and complete including all copies of documents proving my income
- I will notify the Johnson & Johnson Patient Assistance Foundation (JJPAF) Patient Assistance Program within thirty (30) days if there is any change in the status of my eligibility (related to changes in income or health coverage) to receive products through this program. 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.

Patient Authorization To Share Health Information

I allow my doctor(s), any health care providers, and my health plan or insurers to give medical information relating to my use or need for products provided under the Johnson & Johnson Patient Assistance Foundation (JJPAF) Patient Assistance program.

I understand:

- This information can include spoken or written facts about my health and payment benefits
- It can include copies of my health records
- People who work for JJPAF or the Program administrator may see my information but they may use it only to help me get assistance with the costs of my drugs and to run the Program
- Every effort will be made to keep my information private but if it is accidentally given out, federal privacy laws will not protect it
- JJPAF and the Program Administrators reserve the right without notice to change the application form, change the program or program criteria or stop assistance provided by the program at any time
- JJPAF may request and obtain information about my or my family's income
- I can withdraw this consent at any time but it will not change any actions taken before I withdrew consent
- I have a right to see or copy information given to JJPAF or Program Administrators
- This Authorization will last until I am no longer participating in the Program

I KNOW THAT I MAY REFUSE TO SIGN THIS FORM. My choice about whether to sign this form will not change the way health care providers or insurers treat me. If I refuse to sign this form, I know that this means I may no longer be able to receive assistance from the Program.

Patient Name (Print) _____ Date _____

Patient Signature _____
If the patient cannot sign, patient's personal representative must sign below

Patient Representative Signature _____
Describe relationship to patient and authority to make medical decisions for patient:

_____

_____

A copy of this form must be provided to the patient.