

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 \$ _____ (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.**)
 Household Size: _____
 (Number of people who contribute to or are dependent on your household income)
 Value of Assets \$ _____
 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: _____

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.

- | | |
|---|---|
| <input type="checkbox"/> AXERT [®] Tablets (almotriptan malate) | <input type="checkbox"/> SPORANOX [®] (itraconazole) Capsules |
| <input type="checkbox"/> CONCERTA [®] (methylphenidate HCl) Extended-Release Tablets CII | <input type="checkbox"/> TOPAMAX [®] (topiramate) Sprinkle Capsules |
| <input type="checkbox"/> DITROPAN [®] XL (oxybutynin chloride) Extended Release Tablets | <input type="checkbox"/> TOPAMAX [®] (topiramate) Tablets |
| <input type="checkbox"/> DURAGESIC [®] (fentanyl transdermal system) CII | <input type="checkbox"/> ULTRACET [®] (tramadol hydrochloride/acetaminophen) Tablets |
| <input type="checkbox"/> ELMIRON [®] (pentosan polysulfate sodium) Capsules | <input type="checkbox"/> ULTRAM [®] (tramadol hydrochloride) Tablets |
| <input type="checkbox"/> FLEXERIL [®] (cyclobenzaprine HC) Tablets | <input type="checkbox"/> ULTRAM [®] ER (tramadol HCL) Extended-Release Tablets |
| <input type="checkbox"/> LEVAQUIN [®] (levofloxacin) Tablets/Oral Solution | |
| <input type="checkbox"/> RAZADYNE [®] (galantamine HBr) Tablets/Oral Solution | |
| <input type="checkbox"/> RAZADYNE [®] ER (galantamine HBr) Extended-Release Capsules | |

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.

- | | |
|--|---|
| <input type="checkbox"/> ACIPHEX [®] (rabeprazole sodium) | <input type="checkbox"/> PARAFON FORTE [®] DSC (chlorzoxazone) Caplets |
| <input type="checkbox"/> BIAFINE [®] Topical Emulsion | <input type="checkbox"/> REGRANEX [®] (becaplermin) Gel 0.01% |
| <input type="checkbox"/> DOXIL [®] (doxorubicin HCL liposome injection) for intravenous infusion | <input type="checkbox"/> REMICADE [®] (infliximab) for IV Injection |
| <input type="checkbox"/> ERTACZO [™] (sertaconazole nitrate) Cream 2% | <input type="checkbox"/> RETIN-A [®] (tretinoin) Cream, Gel or Micro |
| <input type="checkbox"/> GRIFULVIN V [®] (griseofulvin tablets) microsize & (griseofulvin oral suspension) microsize Tablets/Suspension | <input type="checkbox"/> RISPERDAL [®] CONSTA [®] (risperidone) Long-Acting Injection |
| <input type="checkbox"/> HALDOL [®] (haloperidol) Injection | <input type="checkbox"/> RISPERDAL [®] CONSTA [®] (risperidone) Long-Acting Injection with three week oral Risperdal [®] therapy |
| <input type="checkbox"/> HALDOL [®] (haloperidol) Decanoate Injection | <input type="checkbox"/> SPORANOX [®] (itraconazole) Oral Solution |
| <input type="checkbox"/> LEUSTATIN [®] (cladribine) Injection | <input type="checkbox"/> TERAZOL [®] 3 (terconazole) Vaginal Cream or Suppositories |
| <input type="checkbox"/> NATRECOR [®] (nesiritide) for Injection | <input type="checkbox"/> TERAZOL [®] 7 (terconazole) Vaginal Cream |
| <input type="checkbox"/> ORTHOVISC [®] High Molecular Weight Hyaluronan | |
| <input type="checkbox"/> PANCREASE [®] MT (pancrelipase) Capsules | |

<input type="checkbox"/> ALAMAST [®] (pemirolast potassium ophthalmic solution) 0.1%	Quantity 1 Bottle = 10 ml		Number of Bottles _____
<input type="checkbox"/> BETIMOL [®] (timolol ophthalmic solution) 0.25%, 0.5%	Quantity 1 Bottle = 15 ml	<input type="checkbox"/> 0.25% <input type="checkbox"/> 0.5% (check one)	Number of Bottles _____
<input type="checkbox"/> IQUIX [®] (levofloxacin ophthalmic solution) 1.5%	Quantity 1 Bottle = 5 ml		Number of Bottles _____
<input type="checkbox"/> QUIXIN [®] (levofloxacin ophthalmic solution) 0.5%	Quantity 1 Bottle = 5 ml		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 | <input type="checkbox"/> Pharmacy Card | or | <input type="checkbox"/> Direct to Physician |
| RISPERDAL [®] (risperidone) M-TAB [®] Orally Disintegrating Tablets | <input type="checkbox"/> Pharmacy Card | or | <input type="checkbox"/> Direct to Physician |
| INVEGA [™] (paliperidone) Extended-Release Tablets | <input type="checkbox"/> Pharmacy Card | or | <input type="checkbox"/> Direct to Physician |
| PROCRT [®] (Epoetin alfa) FOR INJECTION | <input type="checkbox"/> Pharmacy Card | or | <input type="checkbox"/> Direct to Physician |
| PREZISTA [®] (darunavir) Tablets | <input type="checkbox"/> Pharmacy Card | or | <input type="checkbox"/> Direct to Physician |
| INTELENCE [™] (etravirine) Tablets | <input type="checkbox"/> Pharmacy Card | or | <input type="checkbox"/> Direct to Physician |

Please check box to indicate if patient is currently on PREZISTA[®] or INTELENCE[™]

Patient Name: _____

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 _____ Product #2 Name _____
Dosage: _____ Sig: _____ Dosage: _____ Sig: _____
Quantity: _____ Quantity: _____
Date: _____ Date: _____
Number of Refills (maximum 12): _____ 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.

To the best of my knowledge, this patient does not have prescription drug insurance coverage (including Medicaid, county funded, or other public programs) for the product(s) listed above. Janssen Ortho Patient Assistance Foundation (JOPAF) 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. JOPAF 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. Also, these goods may not be sold or traded and may not be returned for credit. Please indicate that you agree to these terms by signing below. Your signature confirms that there is a valid medical need for this patient's prescription.

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 Janssen Ortho Patient Assistance Foundation (JOPAF) 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 Janssen Ortho Patient Assistance Foundation (JOPAF) 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 JOPAF 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
- JOPAF 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
- JOPAF 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 JOPAF 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.