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 $ _____

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

Value of Assets $ _____

(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: _____

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 HCl) 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
- ☐ RAZADYNE® (galantamine HBr) Tablets/Oral Solution
- ☐ RAZADYNE® ER (galantamine HBr) Extended-Release Capsules
- ☐ 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 & (griseofulvin oral suspension) microsize Tablets/Suspension
- ☐ HALDOL® (haloperidol) Injection
- ☐ HALDOL® (haloperidol) Decanoate Injection
- ☐ LEUSTATIN® (cladribine) Injection
- ☐ NATRECOR® (nesiritide) for Injection
- ☐ ORTHOVISC® High Molecular Weight Hyaluronan
- ☐ PANCREASE® MT (pancrelipase) Capsules
- ☐ PARAFON FORTE® DSC (chlorzoxazone) Caplets
- ☐ REGRANEX® (becaplermin) Gel 0.01%
- ☐ 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
- ☐ 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™ ☐

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

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.