NOTE: Please read the Patient Eligibility Requirements on the reverse side prior to completing this form.

RemiStart®
Patient Rebate Program for REMICADE® (infliximab)

PATIENT ENROLLMENT FORM

Phone: (888) ACCESS-1 (222-3771) **Fax: (877) 234-3048**

PATIENT INFORMATION	PATIENT NAME		
DATE OF BIRTH / /	GENDER: ☐ MALE ☐ FEMALE	EMPLOYER NAME	
HOME PHONE ( )	WORK PHONE ( )	EMAIL	
MAILING ADDRESS	CITY	STATE	ZIP CODE

PRIMARY INSURANCE INFORMATION (Fill out entirely or fax a copy of your insurance card, both sides)	PRIMARY INSURANCE CO.	SUBSCRIBER NAME	
SUBSCRIBER ADDRESS	CITY	STATE	ZIP CODE
POLICY NUMBER	GROUP NUMBER	GROUP NAME	

SECONDARY INSURANCE INFORMATION (Fill out entirely or fax a copy of your insurance card, both sides)	SECONDARY INSURANCE CO.	SUBSCRIBER NAME	
SUBSCRIBER ADDRESS	CITY	STATE	ZIP CODE
POLICY NUMBER	GROUP NUMBER	GROUP NAME	

By submitting this form, I am requesting to be enrolled in the RemiStart® Patient Rebate Program (the "Program") for REMICADE®. I understand that my personal information will be used by Centocor Ortho Biotech Inc., The Lash Group, Inc., TheraCom, LLC, and TrialCard, Inc. (the "Companies"), in connection with the Program, to investigate my insurance coverage for REMICADE®, help me get assistance with the costs of my REMICADE® therapy, or as otherwise required or allowed under the law. I understand that the Companies may de-identify my information and use or disclose the de-identified information for any purpose permitted by law. I understand that they will take commercially reasonable efforts to keep my information private.

I understand that the Companies may contact me by telephone, postal mail, or email (if I provide an email address) in connection with my enrollment in the Program. I understand and agree that by enrolling in the Program I may also enroll in the care coordination services provided by the AccessOne® Program, a Centocor Ortho Biotech Inc. support system for REMICADE® and other Centocor Ortho Biotech Inc. products. If I choose to participate in care coordination, these services may include providing educational materials related to my therapy and making reminder calls prior to and following my infusion dates. AccessOne® will also contact my doctor as necessary to administer these services.

I understand that my doctor or I will need to submit my original Explanation of Benefits (EOB) to TrialCard, Inc., following each infusion. TrialCard, Inc., will use this information to determine the amount of costs for REMICADE® that Centocor Ortho Biotech Inc. will reimburse. That amount will be credited to my Program rebate card. I further understand that if my doctor or I do not submit an original EOB, TrialCard, Inc., cannot process my rebate request. I also understand that AccessOne® and TrialCard, Inc. will share Program related information with my doctor.

I understand that I can get out of the Program at any time by notifying AccessOne® or TrialCard, Inc., in writing. I understand that, if I am enrolled into the Program, Centocor Ortho Biotech Inc. will not be responsible for lost or stolen rebate cards or for any misuse of these cards.

Fax or mail this completed enrollment form to RemiStart®: Fax: (877) 234-3048 Mail: RemiStart® • 6501 Weston Parkway, Suite 370 • Cary, NC 27513

My signature below certifies that I have completed all of the above sections (including primary and secondary insurance information) completely, accurately, and to the best of my knowledge, and that I have read, understand, and agree to the Patient Authorization to release my Protected Health Information as indicated on the reverse side of this form, including but not limited to spoken or written facts about my health and payment benefits that I may have. It can include copies of records from my healthcare providers or health plans about my health or healthcare. I understand, accept, and comply with all requirements and restrictions described in the eligibility requirements provided on the back of this form and I understand that redeeming this rebate is consistent with the requirements of my health plan.

Patient Signature _____ **Date** _____ **Patient Name** _____
If the patient cannot sign, patient's personal representative must sign below (Please print)

Patient Name _____ **By** _____
(Signature of person signing for patient)

Describe relationship to patient and authority to make medical decisions for patient _____

MEDICAL HISTORY
(Check all codes that apply)

If using more than one diagnosis, please circle the primary diagnosis

Crohn's Disease
- ☐ 555.0 Regional enteritis, small intestine
- ☐ 555.1 Regional enteritis, large intestine
- ☐ 555.2 Regional enteritis, small and large intestine
- ☐ 555.9 Regional enteritis, unspecified site

Fistula (Secondary to Crohn's disease)
- ☐ 565.1 Anal fistula
- ☐ 569.81 Intestinal fistula excluding rectum and anus

Ulcerative Colitis
- ☐ 556.0 Ulcerative (chronic) enterocolitis
- ☐ 556.1 Ulcerative (chronic) ileocolitis
- ☐ 556.2 Ulcerative (chronic) proctitis
- ☐ 556.3 Ulcerative (chronic) proctosigmoiditis
- ☐ 556.5 Left-sided ulcerative (chronic) colitis
- ☐ 556.6 Universal ulcerative (chronic) colitis
- ☐ 556.8 Other ulcerative colitis
- ☐ 556.9 Ulcerative colitis, unspecified

Rheumatoid Arthritis
- ☐ 714.0 Rheumatoid arthritis
- ☐ 714.2 Other RA with visceral or systemic involvement

Psoriatic Arthritis
- ☐ 696.0 Psoriatic anthropathy

Psoriasis
- ☐ 696.1 Psoriasis

Ankylosing Spondylitis
- ☐ 720.0 Ankylosing spondylitis

PREFERRED SITE OF INFUSION
(Required)

- ☐ Prescribing MD's office
- ☐ Non-prescribing MD's office
- ☐ Home Infusion/Infusion Provider Company
- ☐ Hospital outpatient
- ☐ Other

(Fields below do not need to be completed if information is the same as Physician Information)

Name of physician or infusion provider _____

Physician specialty _____

Site name _____

Physician tax ID # _____

PHYSICIAN INFORMATION	PHYSICIAN'S NAME	
SITE NAME	☐ My office does not accept MasterCard®	☐ This patient is billed directly by a Specialty Pharmacy Provider for REMICADE®
ADDRESS		
CITY	STATE	ZIP CODE
PHONE ( )	FAX ( )	
OFFICE CONTACT		
PHYSICIAN TAX ID #		
PHYSICIAN SPECIALTY		

By signing below, I hereby attest that REMICADE® is clinically appropriate for the patient listed above and that the patient is being prescribed REMICADE® by me for FDA-approved uses. I understand that my signature below does not constitute an endorsement of the RemiStart® program. I also understand that in order to manage this program, The Lash Group, Inc., TheraCom, LLC, and/or, TrialCard, Inc., may contact me to verify information about my patient's treatment with REMICADE® specific to this patient rebate program.

Physician signature _____ Date _____

For assistance or additional information, call (888) ACCESS-1 (222-3771), Monday–Friday, 8:00 AM–8:00 PM E.T.

Please read accompanying Medication Guide and Full Prescribing Information for REMICADE® and discuss them with your doctor.

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Centocor Ortho Biotech Inc.

Patient Authorization (PA)

Patients must read this and sign the acknowledgment on the reverse side before they can participate in the Program.

My signature on the reverse side of this form confirms that I allow my doctor(s), any other healthcare providers, specialty pharmacy providers, and my health plan or insurers to share medical information relating to my use or potential use of REMICADE® (infliximab) with Centocor Ortho Biotech Inc., TheraCom, LLC, The Lash Group, Inc., and TrialCard®, Inc. (the "Companies").

The Companies administer AccessOne® and RemiStart® (the "Program") for Centocor Ortho Biotech Inc., marketer of REMICADE®.

This information can include spoken or written facts about my health and payment benefits I may have. It may include copies of records from my healthcare providers or health plans about my health or healthcare.

The Companies may use and share this information to help find alternate funding sources for REMICADE®, investigate my insurance coverage for REMICADE® and perform other related services. The Companies may also share my information with other related parties of this program or as otherwise set forth above.

The Companies will use and share this information to see if I qualify for the Programs and to run the Programs. In addition, the Companies may use and share my information to refer me to other programs, foundations, or alternate sources of funding or coverage that may be available to provide assistance to me with costs of my medication. Program management employees of the Companies may also see my information, but they may use it only in connection with the Program, to help me get assistance with the costs of my medication, or as otherwise required or allowed under the law. I understand that they will make every effort to keep my information private, but if it is accidentally shared with an associated party, federal privacy laws will not protect it.

This Authorization will last until I am no longer participating in the Program. If I change my mind, I can inform my healthcare providers and my insurers in writing that I do not want them to share any information with AccessOne® and RemiStart® (Centocor Ortho Biotech Inc., TheraCom, LLC, The Lash Group, Inc., and TrialCard, Inc.), but will not change any information shared before I notified them of my desire to discontinue. I know that I have a right to see or copy the information my healthcare providers or insurers have given to the Companies.

I understand that I am not required to sign this form on the reverse side. My choice about whether to sign this form will not change the way my healthcare providers or insurers treat me. If I refuse to sign on the reverse side of this form, I know that this means I will not be able to receive assistance from the Program.

A copy of this signed Patient Authorization must be provided to the patient.

Patient Eligibility Requirements for the RemiStart® Program

RemiStart® is available to patients who:

- Are beginning or are currently receiving treatment with REMICADE®
- Are being treated for an FDA-approved indication for REMICADE®
- Currently have commercial insurance that covers medication costs for REMICADE®, but whose medication co-payment is greater than $50 per infusion

Other Restrictions:

- This offer is not valid for residents of Massachusetts
- This offer may not be combined with any other coupon, discount, prescription savings card, free trial, or other offer
- This program is not available to individuals enrolled in federal or state subsidized healthcare programs that cover prescription drugs, including Medicare, such as Medicare Part D prescription drug benefit, Medicaid, TRICARE, or any other federal or state healthcare plan, including pharmaceutical assistance programs. Participants certify that they will not seek reimbursement or compensation from any of these programs, to include a flexible spending account, a Health Savings Account (HSA), or a Health Reimbursement Account (HRA)
- The selling, purchasing, trading, or counterfeiting of this card is prohibited
- Offer good only in the U.S. and Puerto Rico. Centocor Ortho Biotech Inc. reserves the right to rescind, revoke, or amend this offer without notice at any time. Void where prohibited, taxed, or otherwise restricted by law

How can I enroll?

1. Review the eligibility requirements above. Complete and sign the other side of this form, and make sure you obtain your doctor's signature.

2. Fax or mail this enrollment form to RemiStart®
Fax: (877) 234-3048 Mail: RemiStart®, 6501 Weston Parkway, Suite 370, Cary, NC 27513

If I enroll successfully, what rebate will I be eligible for?

- Depending on your co-pay, deductible, or co-insurance, you may qualify for a rebate of $550 or more per infusion.

NOTE: Your signature on the opposite side of this form certifies:

- That you understand, accept, and comply with all requirements and restrictions described above, and that redeeming this rebate is consistent with the requirements of your health plan.
- That you have read, understand, and agree to the Patient Authorization to release your Protected Health Information as indicated above, including but not limited to spoken or written facts about your health and payment benefits you may have. It can include copies of records from your healthcare providers or health plans about your health or healthcare.