Benefit Investigation Form for XARELTO®

Please complete and fax this form to 1-888-927-3587 or mail to P.O. Box 247, Monroeville, PA 15146.

Patient Information

NAME (First, MI, Last)_____ SEX ☐ M ☐ F DOB (MM/DD/YYYY)_____

ADDRESS_____ CITY_____

STATE_____ ZIP CODE_____ E-MAIL_____

HOME PHONE_____ CELL PHONE_____ WORK PHONE_____

Insurance Information (Complete this section or provide a copy of insurance card)

PRIMARY INSURANCE_____

CARDHOLDER_____

RELATIONSHIP TO CARDHOLDER_____

EMPLOYER_____ INS. CO. PHONE_____

POLICY#_____

GROUP#_____

SECONDARY INSURANCE_____

CARDHOLDER_____

RELATIONSHIP TO CARDHOLDER_____

EMPLOYER_____ INS. CO. PHONE_____

POLICY#_____

GROUP#_____

PRESCRIPTION DRUG INSURER_____ CARD/BIN#_____ PHONE_____

(Please include alpha prefix and suffix with policy and group# when applicable)

Patient Authorization for XARELTO® CarePath™ Services (Patient should read the Patient Authorization on the Patient Copy and sign below)

My signature below certifies that I have read, understand, and agree to the Patient Authorization to release my protected health information to Janssen Pharmaceuticals, Inc., and companies working on their behalf, including vendors, other affiliates, and other service providers supporting XARELTO® CarePath™ as defined on the Patient Copy (collectively, "Janssen Pharmaceuticals, Inc.").

I would be interested in receiving additional information about enrolling in XARELTO® CarePath™, a support program for patients and caregivers. ☐ Yes ☐ No

I authorize XARELTO® CarePath™ to leave a message, including the prescription name XARELTO®, if I am unavailable when they call. ☐ Yes ☐ No

PATIENT SIGNATURE_____ DATE_____ PATIENT NAME_____

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

PATIENT NAME_____ BY_____

Signature of person legally authorized to sign for patient

NAME OF PERSON LEGALLY AUTHORIZED TO SIGN_____ RELATIONSHIP_____ PHONE NUMBER_____

Prescriber Information (Verification of Benefits will be faxed to this Prescriber)

PRACTICE NAME_____

PRESCRIBER NAME (First, Last)_____ SPECIALTY_____

ADDRESS_____

CITY_____ STATE_____ ZIP CODE_____

PHONE_____ FAX_____

OFFICE CONTACT_____

MEDICAID/MEDICARE PROVIDER#_____ TAX ID#_____

STATE LICENSE#_____ UPIN/NPI#_____

Clinical Information

DIAGNOSIS ☐ 427.31 Atrial Fibrillation Dosage: ☐ 15 mg ☐ 20 mg

☐ 81.51 Total Hip Replacement ☐ 81.54 Total Knee Replacement DATE OF PROCEDURE_____

☐ 451.x DVT ☐ 453.x DVT ☐ 415.x PE

I would be interested in having XARELTO® CarePath™ contact my patient for a dose change reminder ☐ Yes ☐ No

☐ COMMENT/OTHER_____

Prior Authorization—If you would like XARELTO® CarePath™ to provide support for the prior authorization process, please check the appropriate box(es):

☐ **Prior Authorization Form Assistance**

By checking this box, I request that XARELTO® CarePath™ assist my office in addressing the requirements of this patient's health plan related to prior authorization for treatment with XARELTO®. I understand that assistance includes 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 XARELTO® CarePath™ for possible submission to the health plan.

☐ **Prior Authorization Status Monitoring**

By checking this box, I request that XARELTO® CarePath™ actively monitor the status of the prior authorization submission. I request that XARELTO® CarePath™ provide status updates to my office with respect to this patient's prior authorization for treatment with XARELTO®.

For assistance or additional information, call 1-888-XARELTO (1-888-927-3586), Monday–Friday, 8:00 AM–8:00 PM, ET.

Patient insurance benefit investigation is provided as a service by the support services administrator under contract for Janssen Pharmaceuticals, Inc. In this regard, the support services administrator assists healthcare professionals 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 healthcare provider under appropriate authorization following the provider's exclusive determination of medical necessity.

Importantly, insurance verification is the ultimate responsibility of the provider. Third-party reimbursement is affected by many factors. Therefore, the support services administrator, and Janssen Pharmaceuticals, Inc., make no representation or guarantee that full or partial insurance reimbursement or any other payment will be available. This information is provided as an information service only. While the support services administrator tries to provide correct information, it and Janssen Pharmaceuticals, Inc., make no representations or warranties, expressed or implied, as to the accuracy of the information. In no event shall the support services administrator or Janssen Pharmaceuticals, Inc., or its employees or agents be liable for any damages resulting from or relating to the services. All providers and other users of this information agree that they accept responsibility for the use of this service.

Janssen Pharmaceuticals, Inc., assumes no responsibility for, and does not guarantee, the quality, scope, or availability of the services, including but not limited to reimbursement support services, patient education, and other support services. Each provider, not Janssen Pharmaceuticals, Inc., is responsible for the services they provide. These support services have no independent value to providers apart from the product and are included within the cost of the product.

Before prescribing XARELTO® (rivaroxaban), please see full Prescribing Information, including Boxed WARNINGS and Medication Guide, available at www.XARELTOhcp.com.

janssen
PHARMACEUTICAL COMPANIES
OF Johnson&Johnson

Patient Copy

Provider Instructions

1. **Have the patient read this form and sign the acknowledgement on the front of the Benefit Investigation Form for XARELTO® (rivaroxaban).**
2. **Provide the patient with this sheet and a copy of the front of the Benefit Investigation Form for XARELTO® (rivaroxaban) that they have signed.**

PATIENT AUTHORIZATION (PA)

My signature on the front of the Benefit Investigation Form for XARELTO® (rivaroxaban) confirms that I authorize each of my physicians, pharmacists, and other healthcare providers (together, "Healthcare Providers") and each of my health insurers (together, "Insurers") to disclose my protected health information, including but not limited to medical records, information related to my medical condition and treatment, my health insurance coverage, my name, address, telephone number, Social Security number, insurance plan and/or group numbers (together, "Protected Health Information") to Janssen Pharmaceuticals, Inc., its affiliated companies, agents and representatives, including providers of alternate sources of funding for prescription drug costs, and other service providers supporting access programs for Healthcare Providers and patients (XARELTO® CarePath™) (together, "Janssen Pharmaceuticals, Inc.") for the purposes described below.

Specifically, I authorize Janssen Pharmaceuticals, Inc., to receive, use, and disclose my Protected Health Information in order to (i) enroll me in, and contact me and/or the person legally authorized to sign on my behalf, about XARELTO® CarePath™ programs; (ii) provide me and/or the person legally authorized to sign on my behalf with educational materials, information, and services related to XARELTO®; (iii) verify, investigate, assist with, and coordinate my coverage for XARELTO® with my Insurers; (iv) coordinate prescription fulfillment; and (v) assist with analyses related to the quality, efficacy, and safety of XARELTO®. Furthermore, I understand that my Protected Health Information will not be used or disclosed by Janssen Pharmaceuticals, Inc., for any other purpose unless permitted by law or unless information that specifically identifies me is removed. I understand that Janssen Pharmaceuticals, Inc., will make every effort to keep my information private. If my information is accidentally shared, federal privacy laws do not require that the person/party receiving it not disclose the information further. Information disclosed under these circumstances and provided to a third party may no longer be protected by federal privacy laws. I understand that I am not required to sign the front of the Benefit Investigation Form for XARELTO® (rivaroxaban). My choice about whether to sign will not change the way my Healthcare Providers or Insurers treat me. If I refuse to sign the front of the Benefit Investigation Form for XARELTO® (rivaroxaban), or revoke my authorization later, I understand that this means I will not be able to participate or receive assistance from XARELTO® CarePath™.

I understand that I may cancel (revoke) this Authorization at any time by mailing a letter to XARELTO® CarePath™, c/o TheraCom, LLC, P.O. Box 247, Monroeville, PA, 15146. I can also revoke my authorization by informing my Healthcare Providers and Insurers in writing that I do not want them to share any information with Janssen Pharmaceuticals, Inc., but this will not affect Janssen Pharmaceuticals, Inc.'s ability to use and disclose Protected Health Information that it has received prior to its receipt of notification that I wish to discontinue my participation in the program. My authorization will also end if XARELTO® CarePath™ is discontinued. Furthermore, I understand that I have the right to see or copy the Protected Health Information my Healthcare Providers or Insurers have given to Janssen Pharmaceuticals, Inc.

Please read the full Prescribing Information for XARELTO® (rivaroxaban), including Boxed WARNINGS and Medication Guide, available at www.XARELTOhcp.com, and discuss any questions or concerns with your doctor.

For assistance or additional information, call 1-888-XARELTO (1-888-927-3586), Monday–Friday, 8:00 AM–8:00 PM, ET.

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