Stelara® (ustekinumab) Prescription Information and StelaraSupport™ Enrollment Form

Complete and fax this form to 1-866-769-3903 or mail to P.O. Box 218, Monroeville, PA 15146-2230.

UPDATE 6.15

1. PATIENT INFORMATION (Required)

NAME (First, MI, Last) _____ SEX ☐ M ☐ F

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____ DOB (MM/DD/YYYY) _____

E-MAIL _____

CELL PHONE _____ HOME PHONE _____ WORK PHONE _____

PREFERRED NUMBER TO CALL ☐ Cell ☐ Home ☐ Work BEST TIME TO CONTACT ☐ Morning ☐ Afternoon ☐ Evening

2. INSURANCE INFORMATION (Required. Include alpha prefix and suffix with policy and group# when applicable or provide a copy of insurance cards)

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 _____

NOTE: Pharmacy benefits will be investigated. If patient does not have a pharmacy benefit, medical benefits will be investigated.

3. PATIENT AUTHORIZATION (To be completed only when [1] there is not a valid Business Associate Agreement with the Covered Entity, or [2] the Covered Entity has signed a Limitation of Services request. 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 Biotech, Inc., its parent or affiliate, designee or successor, specialty pharmacies, and other service providers supporting StelaraSupport™ as defined on the Patient Copy (collectively, "Janssen Biotech").

PATIENT SIGNATURE _____ DATE _____

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

PATIENT NAME _____

PATIENT NAME _____ BY _____

Signature of person legally authorized to sign for patient/relationship

4. STELARASUPPORT™ EXTENDED SERVICES ENROLLMENT (To be completed by a patient who wishes to enroll for Extended Services.) Patient should read the Extended Services Enrollment on the Patient Copy, check the appropriate boxes, and sign below:

My signature below certifies that I agree to enroll in the StelaraSupport™ Extended Services that I have checked below, and that I have read, understand, and agree to the Patient Authorization per the terms on the Patient Copy.

Of the optional extended services provided by StelaraSupport™, I would like to enroll to receive:

☐ **Patient Education Materials** ☐ **Patient Therapy Reminders** ☐ **Both**

Patient must sign and check the appropriate boxes above in order to participate or receive assistance from StelaraSupport™ for extended services.

PATIENT SIGNATURE _____ DATE _____

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

PATIENT NAME _____

PATIENT NAME _____ BY _____

Signature of person legally authorized to sign for patient/relationship

5. PRIOR AUTHORIZATION SERVICES (Automatically provided with benefit investigation. You may opt-out by checking the box[es] below)

Prior Authorization Form Assistance StelaraSupport™ assists your office in providing the requirements of patient's health plan related to prior authorization for treatment with STELARA®. Assistance includes obtaining the health plan-specific prior authorization form, and providing it based upon the patient-specific information provided on this form. The partially-completed prior authorization form will be provided to your office for possible completion and submission to the health plan.

I do **NOT** wish to receive Prior Authorization Form Assistance. ☐

Prior Authorization Status Monitoring StelaraSupport™ actively monitors the status of prior authorization submission to patient's plan and provides status updates to your office with respect to this patient's prior authorization for treatment with STELARA®.

I do **NOT** wish to receive Prior Authorization Status Monitoring. ☐

For assistance or additional information, call 1-877-STELARA (1-877-783-5272), Monday–Friday, 8:00 AM–8:00 PM, ET

6. PRESCRIBER INFORMATION (Required)

PRESCRIBER NAME (First, Last) _____

SPECIALTY _____

PRACTICE NAME _____ OFFICE CONTACT _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

E-MAIL _____ PHONE _____ FAX _____

MEDICAID/MEDICARE PROVIDER# _____ TAX ID# _____

STATE LICENSE# _____ UPIN/NPI# _____

7. PRIOR MEDICATIONS (Required)

☐ Amevive*† ☐ Corticosteroids ☐ Cyclosporine ☐ Enbrel* ☐ Humira*

☐ Methotrexate ☐ Otezla* ☐ Phototherapy ☐ Raptiva*‡ ☐ Soriatane*

8. CLINICAL INFORMATION (Required)

PRIMARY DIAGNOSIS ☐ 696.0 Psoriatic arthropathy ☐ 696.1 Psoriasis ☐ Other _____

SECONDARY DIAGNOSIS ☐ 696.0 Psoriatic arthropathy ☐ 696.1 Psoriasis ☐ Other _____

TB EVALUATION ☐ Yes ☐ No DATE OF DIAGNOSIS OR YEARS WITH DISEASE _____

PATIENT WEIGHT _____ lb. _____ kg. % BSA AFFECTED _____

9. PRESCRIPTION INFORMATION (If requesting benefits investigation only, do not complete this section. The prescription is only valid if received by fax. SPECIAL NOTE: New York Prescribers please submit prescription on an original NY State prescription blank. For all other states, if not faxed, prescription must be submitted on state-specific blank, if applicable for your state)

Rx **STELARA®** ☐ **45 mg** ☐ **90 mg**

DIRECTIONS:

STARTER DOSES REQUESTED SHIP DATE _____

☐ 2 single-use prefilled syringes; 45 mg SC at Week 0 and Week 4

☐ 2 single-use prefilled syringes; 90 mg SC at Week 0 and Week 4

MAINTENANCE THERAPY REQUESTED SHIP DATE _____

☐ 1 single-use prefilled syringe; 45 mg SC every 12 weeks Refills # _____

☐ 1 single-use prefilled syringe; 90 mg SC every 12 weeks Refills # _____

PRESCRIBER SIGNATURE (NO STAMPS ALLOWED) REQUIRED TO VALIDATE PRESCRIPTION: I certify that therapy with STELARA® is medically necessary for this patient. I will be supervising the patient's treatment accordingly, and I have reviewed the current STELARA® Prescribing Information. I authorize StelaraSupport™ to act on my behalf for the limited purposes of transmitting this prescription to the appropriate pharmacy designated by me, the patient, or the patient's plan.

PRESCRIBER SIGNATURE (Dispense as written) _____ DATE _____

SUPERVISING PHYSICIAN SIGNATURE (if applicable) _____ DATE _____

SUPERVISING PHYSICIAN NAME _____

10. PREFERRED SPECIALTY PHARMACY (Provider to check one below)

As the treating physician, I have discussed preference for a Specialty Pharmacy (SP) with this patient. This patient prefers use of the SP indicated below. I authorize Janssen Biotech, Inc., and its representatives to fax this prescription to: **1.** The SP designated as checked below, provided it is approved by this patient's plan. **2.** If the SP designated is not a plan-approved SP, then to a SP approved by this patient's plan. **3.** If there is no preferred SP indicated, then to any SP approved by this patient's plan.

☐ Aetna ☐ Accredo/CuraScript ☐ CIGNA Tel-Drug ☐ CVS Caremark ☐ Diplomat

☐ Medco ☐ Optum Rx (Prescription Solutions) ☐ Total Life Care Pharmacy ☐ Walgreens/BioScrip

☐ Other _____

11. SHIPPING INFORMATION (Required to complete benefit investigation even if not prescribing)

SHIP TO: ☐ PROVIDER OFFICE ☐ PATIENT'S HOME ☐ OTHER

ADDRESS _____ CITY _____

STATE _____ ZIP CODE _____ PHONE _____ FAX _____

*Indicated trademarks are registered trademarks of their respective owners. Amevive® (alefacept), Enbrel® (etanercept), Humira® (adalimumab), Otezla® (apremilast), Raptiva® (efalizumab), Soriatane® (acitretin). †On December 15, 2011, Amevive was voluntarily withdrawn from the U.S. market. ‡On April 8, 2009, Raptiva was voluntarily withdrawn from the U.S. market.

Patient insurance benefit investigation is provided as a service by The Lash Group, Inc., under contract for Janssen Biotech, Inc. In this regard, The Lash Group, Inc., 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 Lash Group, Inc., and Janssen Biotech, 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 Lash Group, Inc., tries to provide correct information, they and Janssen Biotech make no representations or warranties, expressed or implied, as to the accuracy of the information. In no event shall The Lash Group, Inc., or Janssen Biotech, 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 Biotech assumes no responsibility for, and does not guarantee the quality, scope, or availability of the services including but not limited to reimbursement support services, coordination of prescription fulfillment, patient education, and other support services. Each provider, not Janssen Biotech, 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.

Please click to read the full Prescribing Information and Medication Guide for STELARA® (ustekinumab). Provide the Medication Guide to your patients and encourage discussion.

janssen
PHARMACEUTICAL COMPANIES
OF Johnson&Johnson

Patient Copy

Provider Instructions

1. **Have the patient read this form and sign the acknowledgements on the front of the Prescription Information and StelaraSupport™ Enrollment Form relating to the Patient Authorization and StelaraSupport™ Extended Services Enrollment.**
2. **Provide the patient with this sheet and a copy of the front of the Prescription Information and StelaraSupport™ Enrollment Form which they have signed.**

PATIENT AUTHORIZATION (PA)

My signature on the front of the Prescription Information and StelaraSupport™ Enrollment Form confirms that I authorize each of my physicians, pharmacists, including any specialty pharmacy which receives my prescription for STELARA® (ustekinumab) 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 Biotech, 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 (StelaraSupport™) (together, "Janssen Biotech") for the purposes described below.

Specifically, I authorize Janssen Biotech to receive, use, and disclose my Protected Health Information in order to (i) enroll me in, and contact me about, StelaraSupport™ programs; (ii) provide me with educational materials, information, and services related to STELARA®; (iii) verify, investigate, assist with, and coordinate my coverage for STELARA® with my Insurers; (iv) coordinate prescription fulfillment; and (v) assist with analyses related to the quality, efficacy, and safety of STELARA®, and patient access to and adherence to STELARA®. I also understand that pharmacies that ship my medication may be paid to share this information with StelaraSupport™ to help provide the offerings requested for me. Furthermore, I understand that my Protected Health Information will not be used or disclosed by Janssen Biotech for any other purpose unless permitted by law or unless information that specifically identifies me is removed. I understand that Janssen Biotech 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. For additional information on how Janssen Biotech collects, uses, and discloses personal information visit www.janssenbiotech.com/privacy-policy.

I understand that I am not required to sign the front of the Prescription Information and StelaraSupport™ Enrollment Form. 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 Prescription Information and StelaraSupport™ Enrollment Form, or revoke my authorization later, I understand that this means I will not be able to participate or receive assistance from StelaraSupport™.

This authorization will last until I am no longer participating in StelaraSupport™. I understand that I may cancel this Authorization at any time by mailing a letter requesting such cancellation to StelaraSupport™, c/o The Lash Group, Inc., P.O. Box 218, Monroeville, PA 15146-2230. 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 Biotech, but this will not affect Janssen Biotech'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 StelaraSupport™ 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 Biotech.

StelaraSupport™ EXTENDED SERVICES ENROLLMENT

By checking the appropriate boxes and signing the front of this Prescription Information and StelaraSupport™ Enrollment Form, I agree to enroll in the extended service(s) provided by the StelaraSupport™ Program. StelaraSupport™ will provide the extended services that I have chosen related to my use of STELARA® including, but not limited to, patient education and other support services; for example, educational brochures and treatment reminder calls, emails, or text messages.

To support the extended services that you select, your name, address, and other information that you give us will be used by Janssen Biotech, Inc., the marketer of STELARA®, and companies that work with Janssen Biotech, including other affiliates and parent companies, to support the Program. We will also use the information you give us to learn more about the patients who use STELARA® and to improve the information we provide to patients who are being treated with STELARA®. Janssen Biotech will not share your information with anyone else except as stated above as required by law. If you want to stop receiving this information from Janssen Biotech, you may ask us to remove you from our contact list by calling 1-877-783-5272.

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.fda.gov/medwatch, or call 1-800-FDA-1088.
Please click to read the Medication Guide for STELARA® and discuss any questions you have with your doctor.

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