Partnership for Prescription Assistance

Application Summary

Program Name	Medication	Application Type	Status
Patient Assistance Program	Risperdal Consta® Long-Acting Injection	Form Available	Application Partially Completed and Included
Patient Safety			

PATIENT ASSISTANCE PROGRAM APPLICATION
To Be Completed By Patient

Johnson & Johnson HEALTH CARE SYSTEMS INC.

To apply for assistance, complete this application, attach your most recent federal tax return and return by mail or fax.

Mail to: Patient Assistance Program, PO Box 221857, Charlotte, NC 28222-1857
Telephone: 800-652-6227 Fax: 888-526-5168

PATIENT INFORMATION

Name ______________________ Guardian Name (if appropriate) ______________________

Date of Birth ____________ Gender ☐ Male ☐ Female Primary Telephone ______________________

Social Security # ______________________ Alternate Telephone ______________________

Address, City, State, ZIP ______________________

FINANCIAL INFORMATION (All Values Should Reflect Annual Amounts for Entire Household)

Salary/Wages/Unemployment $ ______________________

Pension/Social Security $ __________ Other $ __________

Supplemental Security Income $ ______________________

Social Security Disability Insurance $ ______________________

Total Gross Annual 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

If "No", will you be eligible for Medicare in the next 12 months? ☐ Yes ☐ No

If "Yes", provide the date you will be eligible for Medicare ______________________

Medicare Policy # ______________________

Did Medicare benefits begin within the past 2 months? ☐ Yes ☐ No

Are you enrolled in a Medicare prescription drug plan? ☐ Yes ☐ No

Insurance Company ______________________ Plan Name / # ______________________

Telephone ______________________ Policy ID # ______________________

Are you eligible for the Low Income Subsidy for Medicare Part D? ☐ Yes ☐ No ☐ Unsure ☐ Application Pending

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., SPAP – State Patient Assistant Program)? ☐ Yes ☐ No ☐ Applied ☐ Not Applied ☐ Application Pending ☐ Waitlisted ☐ 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 __________

APPLICANT DECLARING CHANGE IN INSURANCE COVERAGE

Johnson & Johnson Health Care Systems Inc. is a duly authorized agent for Janssen Ortho Patient Assistance Foundation "JOPAF". "I understand that JOPAF policy requires individuals with access to medicines through an affordable benefit to seek access through that benefit. As such, I promise that I will notify Johnson & Johnson Health Care Systems Inc. and its Patient Assistance Program within 30 (thirty) days by mail at Patient Assistance Program, P.O. Box 221857, Charlotte, NC 28222-1857, OR by telephone at 800-652-6227, OR by fax at 888-526-5168, if there is any change in the status of my eligibility to obtain any drug(s) that I will receive under this Patient Assistance Program through any other resource at any time during my participation in this Patient Assistance Program. I understand that this notification requirement would apply to circumstances including, but not limited to, changes in my eligibility to participate in the Medicare program [due to changes in my age (65+) or disability status (including end-stage renal disease)], or my enrollment in the Medicare Part D prescription drug benefit."

Please indicate your agreement with these terms by signing below.

Patient Signature ______________________ Date __________

APPLICANT DECLARING ACCURATE & COMPLETE INFORMATION

I promise that the information on this form is correct and complete. If needed, Johnson & Johnson Health Care Systems Inc. and its Patient Assistance Program (the "Program") may request and obtain information about my or my family's income to enroll me in the Program. I understand that the Program administrators reserve the right at any time and without notice to modify the application form; modify or discontinue any or all of the Program and the related eligibility criteria; or terminate assistance provided by the Program at any time."

Please indicate your agreement with these terms by signing below.

Patient Signature ______________________ Date __________

Referral Code (Internal Use Only)

PATIENT ASSISTANCE PROGRAM APPLICATION

To Be Completed By Physician

Johnson & Johnson HEALTH CARE SYSTEMS INC.

Complete this form and return by mail or fax. The Program needs to receive both the patient and physician information in order to process the application.

Mail to: Patient Assistance Program, PO Box 221857, Charlotte, NC 28222-1857
Telephone: 800-652-6227 Fax: 888-526-5168

Patient Name ____________________

PHYSICIAN INFORMATION

Physician Name ____________________ Telephone ____________ Fax ____________

Facility Name ____________________ Tax ID # ____________

Business Hours ____________ Office Contact Name ____________ Medicare Provider ID # ____________ National Provider ID # ____________

Address City, State, ZIP ____________________

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 HCI) Extended-Release Tablets CII
- ☐ DITROPAN® (oxybutynin chloride) Tablets & Syrup
- ☐ 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.

- ☐ BIAFINE® Topical Emulsion
- ☐ BICITRA® (sodium citrate & citric acid oral solution, USP)
- ☐ CENTANY™ (mupirocin ointment), 2%
- ☐ ERTACZO™ (sertaconazole nitrate) Cream 2%
- ☐ GRIFULVIN V® (griseofulvin tablets) microsize & (griseofulvin oral suspension) microsize Tablets/Suspension
- ☐ HALDOL® (haloperidol) Injection
- ☐ HALDOL® (haloperidol) Decanoate Injection
- ☐ MYCELEX® (clotrimazole) Troche
- ☐ NATRECOR® (nesiritide) for Injection
- ☐ NEUTRA-PHOS® (oral sodium & potassium phosphate mixture)
- ☐ NEUTRA-PHOS-K® (oral potassium phosphate mixture)
- ☐ PANCREASE® MT (pancrelipase) Capsules
- ☐ PARAFON FORTE® DSC (chlorzoxazone) Caplets
- ☐ POLYCITRA®-K (potassium citrate & citric acid for oral solution, USP)
- ☐ POLYCITRA®-K Crystals (potassium citrate & citric acid for oral solution)
- ☐ POLYCITRA® LC (tricitrates oral solution)
- ☐ POLYCITRA® Syrup (tricitrates oral solution)
- ☐ REGRANEX® (becaplermin) Gel 0.01%
- ☐ 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
- ☐ URISPAS® (flavoxate HCl) Tablets

PHARMACY CARD OR DIRECT TO PHYSICIAN DISTRIBUTION - Check the preferred method of distribution when selecting products below. See limitations above.

Product	Pharmacy Card		Direct to Physician
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

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 prescribing information for each drug selected for Direct to Physician Distribution)

Patient Name ____________________ Product Name ____________________

Dosage ____________ Sig ____________ Quantity ____________ Date ____________

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 completed for continued section above may be 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 ____________

Required for DURAGESIC® CII only:
"I have received a copy of the full prescribing information required for DURAGESIC® CII and I am prescribing this product for chronic pain."

Physician Signature ____________
Date ____________

October 2007

Patient Authorization To Share Health Information

Johnson & Johnson HEALTH CARE SYSTEMS INC.

AUTHORIZATION TO SHARE HEALTH INFORMATION FOR PATIENT ASSISTANCE PROGRAM

Patients must complete this form before they can participate in the Patience Assistance Program.

I, ______________________________, allow my doctor(s), any other health care providers, and my health plan or insurers to give medical information relating to my use or need for products provided under this program to Lash Group. Lash Group runs the Patient Assistance Program (the "Program") for Johnson & Johnson Health Care Systems Inc. Johnson & Johnson Health Care Systems Inc. manages the Program on behalf of its affiliates: Janssen, L.P., McNeil Pediatrics (Division of McNeil-PPC, Inc.), PriCara (Unit of Ortho-McNeil, Inc.), Scios Inc., Ortho-McNeil Neurologics, Inc., Ortho Women's Health & Urology (A Division of Ortho-McNeil Pharmaceutical, Inc.), OrthoNeutrogena (A Division of Ortho-McNeil Pharmaceutical, Inc.), and Johnson & Johnson Wound Management (A Division of ETHICON, Inc.). These affiliate companies make the products that are provided in the Program.

This information can include spoken or written facts about my health and payment benefits. It can include copies of records from my health care providers or health plans about my health or health care. Lash Group and Johnson & Johnson Health Care Systems Inc. will use and give out this information to see if I qualify for the Program and to run the Program. People who work for and with Lash Group and Johnson & Johnson Health Care Systems Inc. may also see my information, but they may use it only to help me get assistance with the costs of my drugs and to operate the Program. I understand that they will make every effort to keep my information private, but if it is accidentally given out, 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 before that time, I can tell my health care providers and my insurers in writing that I do not want them to share any more information with Lash Group or Johnson & Johnson Health Care Systems Inc., but it will not change any actions they took before I told them. I know that I have a right to see or copy the information my health care providers or insurers have given to Lash Group and Johnson & Johnson Health Care Systems Inc.

I KNOW THAT I MAY REFUSE TO SIGN THIS FORM. My choice about whether to sign this form will not change the way my 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.

PATIENT ASSISTANCE PROGRAM ADMINISTRATOR FOR THE PRODUCTS OF:

Partnership for Prescription Assistance

PhRMA's Commitment to Patient Safety:

Good communications are the key to safe and effective use of medications. There is information you should be sure to provide to your doctor, and information you should be sure to find out about your medicine.

Tell each doctor you consult about:
All your symptoms and answer all questions as accurately as you can. This will help the doctor determine your proper treatment.

All the medicine you take, including non-prescription products such as aspirin or laxatives. Keep a list of your medicines, if necessary, or take the containers with you to show the doctor. This is especially important on your first visit to a doctor or if, when traveling, you need to consult someone who is not your regular doctor.

Any bad reaction you have had to a medicine. Adverse reactions, or side effects, may appear as blurred vision, dizziness, nausea, skin rash, or other unusual feelings you did not experience before you took the medicine.

If you routinely drink even small amounts of alcohol each day—such as wine with meals. Your doctor may advise against this while you are taking prescription medication.

My Health Information

Using This Form

- Fill out all of the information that you know. Call a loved one or your health care provider if you need help or have questions concerning your medical information.
- Make three copies of both sides of the completed record. Keep one copy in your wallet or purse, provide one to a family member or friend, and share the other with your health care providers and pharmacists at all visits.
- You should update this record when:
  - Your contact information, insurance provider, health care provider or pharmacy changes.
  - Your medical condition changes.
  - You start or stop taking a medicine.
  - Your health care provider changes the dose of your medicine.
  - You visit the health care provider or pharmacist.

Personal Information		
Name		
Date of Birth		
Phone Number		
Address		
Emergency Contact		
Name Relationship		
Phone Number		
Insurance Provider (if applicable)		
Name Type (e.g., PPO, HMO)		
Member ID Number		
Contact Number		
Primary Care Physician		**Other Physician(s)**
Name		
Address		
Phone Number		

Pharmacy/Drug Store	
Name of Store	
Pharmacist	
Address Phone Number	
My Allergies (e.g., medications, food) Be sure to list adverse reactions and side effects caused by allergies	
My Medical History Be sure to include all medical conditions (e.g., illnesses, surgeries).	

WHAT YOU SHOULD ASK YOUR DOCTOR

Ask your doctor these questions about your prescription medicines:

What is the name of the medicine and what is it supposed to do?

How and when should it be taken?

How long should I continue to take it?

Are there any precautions I should observe while taking the medicine? For example, are there foods or beverages I should avoid while taking the medicine. Any other medicines I should not take? Any limitations on driving vehicles or other activities?

What side effects may occur? Are there any serious side effects that should be reported to the doctor? What should I do if minor side effects occur?

How long should I wait before reporting to the doctor if my symptoms do not improve?

Can the prescription be refilled? Should I check with the doctor before refilling it?

Is there any written information available about the drug?

Use this record to keep track of your medicines. Consult your health care provider to make sure the information you provide is accurate. And be sure to provide a family member, and your health care provider and pharmacist with a copy of the information.

	Name of Medicine	Dose	Frequency (how often and when)	Purpose	Directions/Notes
• Be sure to include all prescription medicines, over-the-counter drugs, vitamins and herbal supplements.					
1					
2					
3					
4					
5					
6					
7					