



Benefit Investigation Form

Please complete this form and provide to AccessOne® by calling 1-888-ACCESS-1 (222-3771) Monday through Friday between the hours of 8:00 AM and 8:00 PM ET or by faxing it to (866) 489-5955.

1. PHYSICIAN INFORMATION (Required)

Physician name _____
Practice name _____
Address _____
City _____ State _____ ZIP _____
Phone _____ Fax _____
Office contact name _____ Ext. _____
Provider specialty _____
Provider # (as it pertains to commercial insurance below) _____
Medicaid/Medicare provider # _____
Tax ID # _____ UPIN/NPI # _____

Are you the prescribing specialist? (Required)

Yes No (If No, complete section 1B)

1B. Name of Referring Specialist

Referring physician specialty _____

2. PATIENT INFORMATION (Required)

Name (First, MI, Last) _____
Address _____
City _____ State _____ ZIP _____
Home phone _____
DOB (MM/DD/YYYY) _____ Gender Male Female

3. PATIENT INSURANCE INFORMATION (Required)

(Fax copy of enlarged patient insurance card(s) or provide the information below)

Insurance company #1 _____
Primary insured name _____
Employer _____
Insurance company phone _____
Policy # _____ Group # _____
(Please include alpha prefix and suffix where applicable)
Insurance company #2 _____
Primary insured name _____
Employer _____
Insurance company phone _____
Policy # _____ Group # _____
(Please include alpha prefix and suffix where applicable)

Is patient a dependent of the insured (child <18 yrs; student >18 yrs)? Check if yes.

4. MEDICAL HISTORY (Check all codes that apply—Required)

(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

Rheumatoid Arthritis

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

Ankylosing Spondylitis

- 720.0 Ankylosing spondylitis

Comment/Other

Date of diagnosis or years with disease _____

Please see accompanying Indications, Important Safety Information, and full Prescribing Information, also available at www.janssenaccessone.com

5. MEDICATIONS (Specify current dosage and time on therapy)

Therapy	Dosage	P = Prior C = Current F = Failure	<3 months	3-6 months	>6 months
<input type="checkbox"/> 5-ASA	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sulfasalazine	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Azathioprine	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 6-MP	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Prednisone	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Methotrexate	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cyclosporine	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Retinoids	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Gold compounds	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hydroxychloroquine	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cyclophosphamide	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Penicillamine	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Leflunomide	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Etanercept	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Anakinra	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Adalimumab	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Abatacept	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Rituximab	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Phototherapy	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. THERAPY WITH REMICADE®

Previous TB test (date) _____
Dosage/frequency _____
Patient weight _____ lb. _____ kg. # of vials to be used _____
Anticipated # of infusions _____
Number of prior REMICADE® infusions unknown 0 1-3 4+
Scheduled date of infusion _____

7. PRIOR AUTHORIZATION

If you would like AccessOne® to provide support for the prior authorization process, please check the appropriate box(es):

Prior Authorization Form Preparation

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

Prior Authorization Status Monitoring

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

8. PREFERRED SITE OF INFUSION (Required)

- Prescribing MD's office Non-prescribing MD's office Other
 - Hospital outpatient Home infusion/Infusion Provider Company
- (Fields below do not need to be completed if information is the same as in section 1)

Physician or infusion provider name _____
Physician specialty _____
Practice/facility name _____
Address _____
City _____ State _____ ZIP _____
Phone _____ Fax _____
Contact name _____
Insurance provider # _____ Tax ID # _____

PATIENT AUTHORIZATION

To comply with the HIPAA Privacy Rule, AccessOne® must have a signed patient authorization and/or business associate agreement on file.

Patient insurance benefit investigation is provided as a service by TheraCom, LLC, and The Lash Group, Inc., under contract for Janssen Biotech, Inc. In this regard, TheraCom, LLC, and The Lash Group, Inc., assist 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, TheraCom, LLC, 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 TheraCom, LLC, and The Lash Group, Inc., try 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 TheraCom, LLC, 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.

Before prescribing REMICADE® (infliximab), please see full Prescribing Information and Medication Guide for REMICADE®, available at www.remicade.com.

Janssen Biotech, Inc.