single-source support for access to Janssen Biotech products

LIMITATION OF SERVICES REQUEST

Please sign below indicating that you prefer your patients **not** be contacted by AccessOne® to receive an explanation of their insurance coverage for Janssen Biotech, Inc. products (see Section IA of the Business Associate Agreement).

By initialing here___________, I request that AccessOne® contact my patients, one time, and ask them if they would like to opt-in to patient support services offered by the AccessOne® program. I understand that the patient may choose not to opt-in to the program or may opt-out of the program at any time.

I acknowledge that my patients may be contacted by AccessOne®, regardless of my signing the form, in one of two ways:

1. if my patients separately execute the AccessOne® patient authorization form; or
2. if my patients contact AccessOne® directly.

Janssen Biotech reserves the right to cancel or modify the AccessOne® program at any time.

Please print.

Name of physician or infusion provider ______________________________

Name of practice/facility ______________________________

Address ______________________________

City ______________________________ County ______________________________

State ______________________________ ZIP Code ______________________________

Authorized signature ______________________________ Date ______________________________

Name/title (please print) ______________________________

Fax completed form to 1-866-489-5955 or mail to AccessOne®, P.O. Box 220829, Charlotte, NC 28222-0829

Phone 1-888-ACCESS-1 (222-3771)
www.janssenaccessone.com

Janssen Biotech, Inc.

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