RemiStart® Patient Rebate Program for REMICADE® (infliximab)

6501 Weston Parkway, Suite 370, Cary, NC 27513 Phone: 888-ACCESS1 (888-222-3771) Fax: 877-234-3048
www.RemiStart.com

Dear Physician or Office Manager,

This form is being sent to you because the Explanation of Benefits (EOB) for

__________________________, DOB _________________ does not indicate that he/she received

(Patient Name) *(Date of Birth)*

REMICADE® (i.e., REMICADE, J1745, infliximab) at his or her infusion on _________. In order to calculate the patient's rebate as part of the RemiStart® program, we require clarification from you on the following information:

___________ Date of Infusion

___________ Number of Vials of REMICADE® Administered

By signing below, you are confirming that the patient received an infusion with REMICADE® of the number of vials you indicated on the date listed above.

____

Name: ________________________

Please fax this form back to 1-877-234-3048 as soon as possible to ensure that this patient receives his or her rebate promptly.

If you have any questions about the RemiStart® Patient Rebate Program for REMICADE®, please call AccessOne® at (888) ACCESS-1 (222-3771) or visit www.RemiStart.com.

Before prescribing REMICADE®, please see full Prescribing Information, including Boxed Warnings, Contraindications, Warnings and Precautions, Adverse Reactions and Medication Guide available at www.REMICADE.com.

Sincerely,

RemiStart® Patient Rebate Program Manager

© Janssen Biotech, Inc. 2011 9/11 25RSB11234R1

© Janssen Biotech, Inc. 2011 9/11 25RSB11253