



Prescription Information, and SimponiOne® Support Enrollment Form

Please complete and fax this form to (866) 489-5955 or mail to P.O. Box 220829, Charlotte, NC 28222-0829.

Patient Information

NAME (First, MI, Last) _____ SEX M F DOB (MM/DD/YYYY) _____
 ADDRESS _____ CITY _____
 STATE _____ ZIP CODE _____ E-MAIL _____
 HOME/CELL PHONE _____ WORK PHONE _____ BEST TIME TO CONTACT _____

Insurance Information (Complete this section or provide a copy of insurance card)

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 _____ (Please include alpha prefix and suffix with policy and group# when applicable)	CARD/BIN# _____ PHONE _____

Patient Authorization for SimponiOne® Support Services, powered by AccessOne® (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, and specialty pharmacies and other service providers supporting AccessOne® and SimponiOne® Support as defined on the Patient Copy (collectively, "Janssen Biotech"). SimponiOne® Support services are part of AccessOne®.

PATIENT SIGNATURE _____ DATE _____ PATIENT NAME _____
 If patient cannot sign, patient's legally authorized representative must sign below.
 PATIENT NAME _____ BY _____
 Signature of person legally authorized to sign for patient/relationship

SimponiOne® Support 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 SimponiOne® Support 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 SimponiOne® Support, 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 SimponiOne® Support for extended services.

PATIENT SIGNATURE _____ DATE _____ PATIENT NAME _____
 If patient cannot sign, patient's legally authorized representative must sign below.
 PATIENT NAME _____ BY _____
 Signature of person legally authorized to sign for patient/relationship

Prescriber Information

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# _____

Clinical Information

DIAGNOSIS 714.0 Rheumatoid Arthritis 714.2 Other Rheumatoid Arthritis with visceral or systemic involvement 696.0 Psoriatic Arthropathy 720.0 Ankylosing Spondylitis
 COMMENT/OTHER _____ DATE OF DIAGNOSIS OR YEARS WITH DISEASE _____
 PREVIOUS TB TEST DATE _____
 PRIOR MEDICATIONS: Acetaminophen, ibuprofen, naproxen sodium, or other over-the-counter pain relievers Humira* Calcipotriene Celebrex* Corticosteroids
 Enbrel* Indocin* Methotrexate Naproxen Azulfidine* Other _____

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 SIMPONI®. 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 SIMPONI®.

Prescription Information (If requesting benefits investigation only, do not complete this section)

Rx: **SIMPONI® (golimumab) 50 mg**
 DIRECTIONS: 1 single-use autoinjector, 50 mg/0.5 mL SC once monthly Refills # _____ 1 single-use prefilled syringe, 50 mg/0.5 mL SC once monthly Refills # _____
 OTHER _____ Refills # _____
 SHIP TO: PROVIDER OFFICE—Initial injection only PATIENT'S HOME—I have instructed the patient in proper injection technique for SIMPONI® and patient will self-administer OTHER
 NAME (if different than above) _____
 ADDRESS _____
 CITY _____ STATE _____ ZIP CODE _____
 PHONE _____ FAX _____

PRESCRIBER SIGNATURE REQUIRED TO VALIDATE PRESCRIPTION: I certify that therapy with SIMPONI® is medically necessary for this patient. I will be supervising the patient's treatment accordingly.
 PRESCRIBER SIGNATURE _____ DATE _____

SUPERVISING PHYSICIAN NAME (if applicable) _____

For assistance or additional information, call (888) ACCESS-1 (1-888-222-3771), Monday–Friday, 8:00AM–8:00PM, ET

*Indicated trademarks are registered trademarks of their respective owners. Humira® (adalimumab), Celebrex® (celecoxib), Enbrel® (etanercept), Indocin® (indomethacin), Azulfidine® (sulfasalazine).

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 providers' 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 SIMPONI[®], please see full Prescribing Information including Boxed Warnings, Warnings and Precautions, Adverse Reactions, and Medication Guide, available at www.simponi.com.

Janssen Biotech, Inc.

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Patient Copy

Provider Instructions

1. Have the patient read this form and sign the acknowledgements on the front of the Prescription Information for SIMPONI[®] (golimumab) and SimponiOne[®] Support Enrollment Form relating to the Patient Authorization and SimponiOne[®] Support Extended Services Enrollment.
2. Provide the patient with this sheet and a copy of the front of the Prescription Information for SIMPONI[®] (golimumab) and SimponiOne[®] Support Enrollment Form which they have signed.

PATIENT AUTHORIZATION (PA)

My signature on the front of the Prescription Information for SIMPONI[®] (golimumab) and SimponiOne[®] Support Enrollment Form confirms that I authorize each of my physicians, pharmacists, including any specialty pharmacy which receives my prescription for SIMPONI[®] (golimumab) 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 (AccessOne[®]) and patients (SimponiOne[®] Support) (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, SimponiOne[®] Support programs; (ii) provide me with educational materials, information, and services related to SIMPONI[®]; (iii) verify, investigate, assist with, and coordinate my coverage for SIMPONI[®] with my Insurers; (iv) coordinate prescription fulfillment; and (v) assist with analyses related to the quality, efficacy, and safety of SIMPONI[®]. 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. I understand that I am not required to sign the front of the Prescription Information for SIMPONI[®] (golimumab) and SimponiOne[®] Support 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 for SIMPONI[®] (golimumab) and SimponiOne[®] Support Enrollment Form, or revoke my authorization later, I understand that this means I will not be able to participate or receive assistance from AccessOne[®] or SimponiOne[®] Support.

I understand that I may cancel (revoke) this Authorization at any time by mailing a letter to AccessOne[®], c/o The Lash Group, 3735 Glen Lake Drive, Suite 300, Charlotte, NC 28208. 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 AccessOne[®] and SimponiOne[®] Support are 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.

SimponiOne[®] Support EXTENDED SERVICES ENROLLMENT

By checking the appropriate boxes and signing the front of the Prescription Information for SIMPONI[®] (golimumab) and SimponiOne[®] Support Enrollment Form, I agree to enroll in the extended service(s) provided by the SimponiOne[®] Support Program. SimponiOne[®] Support will provide the extended services that I have chosen related to my use of SIMPONI[®] including, but not limited to, patient education and other support services; for example, educational brochures and treatment reminder calls, e-mails, 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 SIMPONI[®], 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 SIMPONI[®] and to improve the information we provide to patients who are being treated with SIMPONI[®]. Janssen Biotech will not share your information with anyone else except as stated above and 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 1-866-222-6410.

Please read the Medication Guide for SIMPONI[®] and discuss any questions or concerns with your doctor.

Janssen Biotech, Inc.

