



# Prescription Information, and STELARA® Support Enrollment Form

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 all insurance cards)

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 _____ CARD/BIN# _____ PHONE _____ (Please include alpha prefix and suffix with policy and group# when applicable)	
PREFERRED SITE OF INJECTION (Optional): Prescriber Office Hospital Outpatient Department Home Health Provider	

## Patient Authorization (To be completed only when [1] there is not a valid Business Associate Contract 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, specialty pharmacies, and other service providers supporting AccessOne® and STELARA® Support as defined on the Patient Copy (collectively, "Janssen Biotech"). STELARA® 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

## STELARA® 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 STELARA® 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 STELARA® 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 STELARA® 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 696.1 Psoriasis COMMENT/OTHER \_\_\_\_\_ TB EVALUATION Yes No  
 DATE OF DIAGNOSIS OR YEARS WITH DISEASE \_\_\_\_\_ PATIENT WEIGHT \_\_\_\_\_ lb. \_\_\_\_\_ kg. % BSA AFFECTED \_\_\_\_\_  
 PRIOR MEDICATIONS: Amevive\* Corticosteroids Cyclosporine Enbrel\* Humira\* Methotrexate Raptiva\*† Phototherapy Soriatane\*

## 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 STELARA®. 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 STELARA®.

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

Rx STELARA® 45 mg 90 mg  
 DIRECTIONS: **STARTER DOSES** REQUESTED SHIP DATE \_\_\_\_\_ **MAINTENANCE THERAPY** REQUESTED SHIP DATE \_\_\_\_\_  
 2 single-use prefilled syringes; 45 mg SC at Week 0 and Week 4 1 single-use prefilled syringe; 45 mg SC every 12 weeks Refills # \_\_\_\_\_  
 2 single-use prefilled syringes; 90 mg SC at Week 0 and Week 4 1 single-use prefilled syringe; 90 mg SC every 12 weeks Refills # \_\_\_\_\_  
 SHIP TO: PROVIDER OFFICE  
 PATIENT'S HOME  
 OTHER ADDRESS \_\_\_\_\_  
 CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_  
 PHONE \_\_\_\_\_ FAX \_\_\_\_\_

### PRESCRIBER SIGNATURE REQUIRED TO VALIDATE PRESCRIPTION

I certify that therapy with STELARA® is medically necessary for this patient. I will be supervising the patient's treatment accordingly.

PRESCRIBER SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
 SUPERVISING PHYSICIAN SIGNATURE (if applicable) \_\_\_\_\_ NAME \_\_\_\_\_ DATE \_\_\_\_\_

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

\*Indicated trademarks are registered trademarks of their respective owners. Amevive® (alefacept), Enbrel® (etanercept), Humira® (adalimumab), Raptiva® (efalizumab), Soriatane® (acitretin).

†On April 8, 2009, Raptiva was voluntarily withdrawn from the U.S. market.

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.

**Please click [here](#) to read the Full [Prescribing Information](#) and [Medication Guide](#) for STELARA®. Provide the Medication Guide to your patients and encourage discussion.**



## Patient Copy

### Provider Instructions

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

## PATIENT AUTHORIZATION (PA)

My signature on the front of the Prescription Information, and STELARA® Support Enrollment Form confirms that I allow my prescriber(s), any other healthcare providers, specialty pharmacy providers (collectively, “healthcare providers”), and my health plan or insurers to share information including medical records, spoken and written facts about my health or health care, payment benefits relating to my health care, and my use or potential use of STELARA® with Janssen Biotech, Inc., its parent or affiliate, designee or successor, specialty pharmacies, providers of alternate sources of funding for prescription drug costs, and other service providers supporting AccessOne® for healthcare providers, or STELARA® Support for patients (collectively, “Janssen Biotech”). AccessOne®, the Janssen Biotech support system, will provide services related to my use of STELARA® including, but not limited to, reimbursement support services and coordination of prescription fulfillment (collectively, “AccessOne®”).

Program management employees of Janssen Biotech may also see my information, but they may use it only in connection with AccessOne®, or as otherwise required or allowed under the law. Janssen Biotech may also share my information with other parties supporting AccessOne®, if they first remove any information that identifies me. I understand that they 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 pursuant to this disclosure and provided to a third party may no longer be protected by federal privacy laws.

This Authorization will last until I am no longer participating in AccessOne®. If I change my mind, I can inform my healthcare providers and my insurers in writing that I do not want them to share any information with Janssen Biotech, but it will not change any information shared before I notified them of my desire to discontinue. My authorization will also end if AccessOne® is discontinued. I know that I have a right to see or copy the information my healthcare providers or insurers have given to Janssen Biotech.

I understand that I am not required to sign the front of the Prescription Information, and STELARA® 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, and STELARA® Support Enrollment Form, or revoke my authorization later, I know that this means I will not be able to participate or receive assistance from AccessOne®.

## STELARA® SUPPORT EXTENDED SERVICES ENROLLMENT

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

**You are encouraged to report negative side effects of prescription drugs to the FDA. Visit [www.fda.gov/medwatch](http://www.fda.gov/medwatch), or call 1-800-FDA-1088.**

**Please click here to read the [Medication Guide](#) and Full [Prescribing Information](#) for STELARA® and discuss any questions you have with your doctor.**

