Stelara®
(ustekinumab)

BENEFITS INVESTIGATION AND PRESCRIPTION FORM

The Benefits Investigation and Prescription Form for STELARA® can be found inside along with tips for easily completing and submitting this form

Please read the enclosed Prescribing Information, including Medication Guide, for STELARA®.

janssen
PHARMACEUTICAL COMPANIES OF
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Once the physician has made the treatment decision to prescribe STELARA®, use the enclosed form to provide information regarding your patient's coverage for STELARA®. Upon completion, submit the form via fax to Janssen CarePath for benefits investigation and/or a prescription for STELARA®.

To ensure this process is completed without delay, please fill out all required sections.

SECTION 1

Patient authorization may be required

If your office does not have a valid Business Associate Agreement in place, you will need the patient's authorization via signature.

If a patient authorization is not required, please discuss with your patient that a benefits investigation will be completed on his or her behalf for the Janssen medication you prescribe.

Check the box at the bottom of this section if the patient plans to enroll in the Nurse Navigator Program

- Tear off and offer the patient the Nurse Navigator Program Enrollment Form attached to the STELARA® Benefits Investigation and Prescription Form
- The patient is free to fill out this form and mail, fax, or e-mail it at his or her leisure

SECTION 2

Providing insurance information is mandatory and critical to processing this form

Option 1: Fax copies of the **front and back** of both the medical insurance **and** prescription insurance cards.
If you choose this option, please fax the copies of the insurance cards at the same time as this completed form.

Option 2: Fill in this section completely.

DON'T FORGET: If you do not provide the pharmacy insurance information, only the medical insurance will be run

SECTION 3

Providing an ICD-10 code and prior medications is mandatory and critical to processing this form

Select one of the ICD-10 codes from the list of common codes. A complete list of ICD-10 codes is available at www.JanssenCarePath.com.

DON'T FORGET: The provider of services is responsible for correct coding

SECTION 4

Enroll patient in Janssen Link, if needed

The Janssen Link Program is for commercially insured patients only. Please see the back of the form for more information.

SECTION 5

Prior authorization assistance is available, if needed

Indicate if you would like assistance with the prior authorization form or if a prior authorization is already on file with the patient's plan.

Janssen CarePath (UPDATE 9.19)

Gastroenterologist Benefits Investigation and Prescription Form

Complete and fax this form to 866-769-3903. For assistance, call 877-CarePath (877-227-3728), Monday–Friday, 8:00 AM–8:00 PM ET

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Janssen CarePath cannot accept any information without an executed Business Associate Agreement or Patient Authorization Form, which can be found at JanssenCarePath.com or as the last page of this document.

1. PATIENT INFORMATION (REQUIRED)

NAME (First, MI, Last) _____ SEX ❑ M ❑ F

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____ DOB (MM/DD/YYYY) _____

PRIMARY PHONE (best number to call 8:00 AM to 8:00 PM) _____

NURSE NAVIGATORS FROM JANSSEN CAREPATH (Patient Enrolled Program)

❑ YES! I (the patient) would like to enroll in the Nurse Navigator Program and will submit the attached enrollment form.

2. INSURANCE INFORMATION (REQUIRED. Complete fields below OR provide a copy of insurance cards.)

MEDICAL INSURANCE _____

CARDHOLDER _____

DATE OF BIRTH _____ POLICY# _____ GROUP# _____

PHARMACY INSURANCE _____ PCN# _____

CARDHOLDER _____ DATE OF BIRTH _____

PHARMACY ID _____ CARD/BIN# _____ GROUP# _____

SECONDARY INSURANCE _____ CARDHOLDER _____

DATE OF BIRTH _____ POLICY# _____ GROUP# _____

3. CLINICAL INFORMATION & PRIOR THERAPIES (REQUIRED. The information requested is for benefits investigation purposes only. Visit JanssenCarePath.com for ICD-10 codes or consult the ICD-10 code book for additional information.)

STELARA®—DIAGNOSIS

❑ K50.00 (Crohn's Disease of small intestine, without complications)
❑ K50.80 (Crohn's Disease of both small and large intestine, without complications)
❑ K50.90 (Crohn's Disease, unspecified, without complications)
❑ K51.90 (Ulcerative Colitis, unspecified, without complications)
❑ K51.00 (Ulcerative [chronic] Pancolitis, without complications)
❑ K51.80 (Other Ulcerative Colitis, without complications)
❑ Other ICD-10 Code _____

DATE OF DIAGNOSIS OR YEARS WITH DISEASE _____ PREVIOUS TB TEST (DATE) _____

PRIOR MEDICATIONS (REQUIRED TO COMPLETE PRIOR AUTHORIZATION)

❑ 5-ASA ❑ 6-MP ❑ Azathioprine ❑ Azulfidine® ❑ Cimzia® ❑ Cyclosporine
❑ Corticosteroids ❑ Entyvio® ❑ Humira® ❑ Methotrexate ❑ Tysabri® ❑ Xeljanz®
❑ None ❑ Other _____

4. JANSSEN LINK PROGRAM

Janssen Link, a program offered by Janssen CarePath, is for eligible patients with commercial insurance who have been prescribed subcutaneous STELARA® for an on-label FDA-approved indication. It enables patients to receive subcutaneous STELARA® at no cost if the patient has commercial insurance that has delayed (>5 business days) or denied their treatment. See program requirements below and on back.
By enrolling patients in Janssen Link, I certify to not purchase the Janssen medication on behalf of Janssen Link patient participants, and not bill commercial payers for any part of the prescribed subcutaneous treatment. I also agree to complete and submit a form of coverage determination (ie, prior authorization or prior authorization with an exception) to the commercial insurance. If coverage is denied, then I agree to challenge the coverage denial with an exception, Letter of Medical Necessity or appeal. I also understand that Janssen CarePath will monitor prior authorization status.

PRESCRIBER SIGNATURE (NO STAMPS ALLOWED) _____ DATE _____

5. PRIOR AUTHORIZATION

Prior Authorization Form Assistance and Status Monitoring: Janssen CarePath assists your office in providing the requirements of the patient's health plan related to prior authorization for treatment with STELARA®. Assistance includes obtaining the health plan-specific prior authorization form, and providing it based upon the patient-specific information provided on this form. The partially completed prior authorization form will be provided to your office for possible completion and submission in the office's sole discretion. Janssen CarePath also actively monitors the status of prior authorization submission to the patient's plan and provides status updates to your office with respect to this patient's prior authorization for treatment with STELARA®.

❑ **I do NOT wish to receive Prior Authorization Form Assistance or Status Monitoring. This opt-out does not apply if you are requesting the patient be enrolled in Janssen Link.**
❑ **Prior Authorization is already on file with the patient's plan for treatment with STELARA® IV.**
❑ **Prior Authorization is already on file with the patient's plan for treatment with subcutaneous STELARA®.**

6. PRESCRIBER INFORMATION (REQUIRED)

PRESCRIBER NAME (First, Last) _____

PRACTICE NAME _____ OFFICE CONTACT _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

PHONE _____ FAX _____

TAX ID# _____ NPI# _____

7. SINGLE IV INDUCTION AND SITE OF INFUSION INFORMATION (Complete this section and provide induction dose information. If requesting benefits investigation or prescription for maintenance dose only, skip to Section 8.)

Please Investigate ❑ **PHARMACY & MEDICAL BENEFITS**

INFUSION INDUCTION DOSE

❑ 55 kg or less — 260 mg (2 x 130 mg/26 mL vials) at Week 0
❑ more than 55 kg to 85 kg — 390 mg (3 x 130 mg/26 mL vials) at Week 0
❑ more than 85 kg — 520 mg (4 x 130 mg/26 mL vials) at Week 0

PATIENT WEIGHT _____ lb. _____ kg. DATE OF INFUSION INDUCTION DOSE _____

SITE OF INFUSION (REQUIRED IF DIFFERENT FROM PRESCRIBING MD's OFFICE)

❑ Non-prescribing MD's office ❑ Hospital outpatient ❑ Infusion center ❑ Other

PHYSICIAN OR INFUSION PROVIDER NAME _____

PRACTICE/FACILITY NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____ FAX _____

NPI # _____ TAX ID # _____

8. MAINTENANCE DOSE INFORMATION (Complete this section if requesting benefits investigation, enrollment in Janssen Link AND/OR a prescription for maintenance dose.)

Please investigate STELARA® 90 mg single-use prefilled syringe ❑ **PHARMACY & MEDICAL BENEFITS**

Please investigate STELARA® 45 mg vials ❑ **PHARMACY & MEDICAL BENEFITS**

SHIPPING INFORMATION FOR MAINTENANCE THERAPY (Required to complete benefits investigation even if not prescribing. NOTE: Shipments cannot be sent to P.O. Boxes)

SHIP TO: ❑ Office ❑ Patient (Payer may require pharmacy benefit use only if selected) ❑ Hospital outpatient ❑ Other

ADDRESS _____ CITY _____

STATE _____ ZIP CODE _____ PHONE _____ FAX _____

Rx STELARA® MAINTENANCE THERAPY (Do not complete this section if requesting benefits investigation only.)

❑ 1 single-use prefilled syringe; **90 mg** SC every 8 weeks — Refills # _____
❑ 2, 45 mg vials; **90 mg** SC every 8 weeks — Refills # _____

DATE OF INFUSION INDUCTION DOSE (IF KNOWN) _____

PRESCRIBER SIGNATURE (NO STAMPS ALLOWED) 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, and I have reviewed the current STELARA® Prescribing Information. I authorize Janssen CarePath to act on my behalf for the limited purposes of transmitting this prescription to the appropriate pharmacy designated by me, the patient, or the patient's plan.

PRESCRIBER SIGNATURE (Dispense as written) _____ DATE _____

Please see the full Prescribing Information and Medication Guide for Stelara®. Provide the Medication Guide to your patients and encourage discussion.

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If you have any questions or need assistance filling out this form, **call Janssen CarePath at 877-CarePath (877-227-3728).**

SECTION 6

Prescriber information is required

Please fill this section out in full. If using the office stamp, please be sure all required fields on the form are included.

SECTION 7

Complete this section in its entirety whether or not the patient has already received, or not yet completed, the IV induction dose

- Confirmation of the single IV induction dose administration is a critical step in the approval process
- Confirmation of the **actual date** of the IV induction dose is important to ensure appropriate scheduling of the subcutaneous maintenance dose
- If you check one of the boxes under SITE OF INFUSION, you **must** fill out the physician facility information completely

DON'T FORGET: Janssen CarePath will automatically run both pharmacy and medical benefits for your patient

To find an infusion center, please visit: www.2infuse.com

SECTION 8

Fill this section out completely if you are prescribing the maintenance dose

STELARA® requires a single IV induction dose followed by subcutaneous maintenance therapy.
If you are requesting benefits investigation only for the IV dose, you may skip this section.

- Please include the date the patient received the IV induction dose of STELARA®
- We can only conduct a benefits investigation for the 45-mg vial. A prescription cannot be written for the 45-mg vial because it is administered by the HCP
- If required by your state, fax the state-specific blank (an actual script) at the same time you fax this form
- **Do not use** the prescriber signature stamp. Actual signatures are required

DON'T FORGET: Janssen CarePath will automatically run both pharmacy and medical benefits for your patient

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