Janssen CarePath | **Nurse Navigators from Janssen CarePath**

Stelara® (ustekinumab)

Enroll now for your dedicated Nurse Navigator

A Nurse Navigator serves as a partner throughout your treatment journey

E-mail completed form to:
mynurse@janssennurse.com

Fax completed form to:
800-870-6237

Mail completed form to:
Nurse Navigators from Janssen CarePath
500 Atrium Drive, 3rd Floor
Somerset, NJ 08873

Enroll online at:
www.Nurse4Stelara.com

Patient Information *Required field.

The information you provide will be used by Johnson & Johnson Health Care Systems Inc., our affiliates, and our service providers for enrollment and participation in the Nurse Navigator program. Our Privacy Policy, which may be found at janssencarepath.com/content/privacy-policy, further governs the use of the information you provide. By completing and submitting this form, you indicate that you read, understand, and agree to these terms.

☐ Mr ☐ Mrs ☐ Ms ☐ Miss

*First Name _____ *Last Name _____

Street Address _____ Apt/Unit _____

City _____ State _____ ZIP Code _____

*Phone (____) _____ ☐ Mobile ☐ Home ☐ Office ☐ Other Secondary Phone (____) _____

Okay to leave message? ☐ Yes ☐ No Okay to text? ☐ Yes ☐ No

*E-mail Address _____ *Date of Birth ____/____/____

_____ ____/____/____

*Patient Authorization Signature Date

If patient cannot sign, patient's legally authorized representative must sign below:

Signature of person legally authorized to sign for patient:

By: _____ Date: _____

Describe relationship to patient and authority to make medical decisions for patient:

_____

E-mail Address _____

*Phone (____) _____ ☐ Mobile ☐ Home ☐ Office ☐ Other Secondary Phone (____) _____

Physician Information

☐ Doctor ☐ Nurse Practitioner ☐ Physician Assistant

Name _____ Street Address _____

City _____ State _____ ZIP Code _____

Phone (____) _____

The nurse program is limited to education for patients about their Janssen therapy and its administration and/or their disease, and it is not intended to provide medical advice, replace a treatment plan from the patient's doctor or nurse, or provide case management services.

Please see the accompanying full Prescribing Information and Medication Guide for STELARA® and discuss any questions you have with your doctor.
Please see reverse for terms of Patient Authorization for Nurse Navigator enrollment.

Janssen | PHARMACEUTICAL COMPANIES OF Johnson & Johnson

Janssen CarePath

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Janssen Field Specialists Patient Authorization Form

My signature on this Janssen Field Specialists Patient Authorization Form (the "Form") confirms I authorize my physician who has ordered a Janssen therapy ("my Physician") and each of my other physicians, pharmacists, including any specialty pharmacy that receives my prescription for a Janssen medication, other healthcare professionals and their staff (together, "Healthcare Providers") and each of my health insurers (together, "Insurers") to disclose my protected health information, including but not limited to information related to my medical condition, treatment, and prescriptions (together, "Protected Health Information"), to Johnson & Johnson Health Care Systems, Inc., Janssen Biotech, Inc., their affiliated companies, agents, and representatives (together, "Janssen"), and any Janssen service providers or employees providing reimbursement, access, disease awareness or product information support to patients and their Healthcare Providers (together, the "Janssen Field Specialists") for the purposes described below.

Specifically, I authorize Janssen and the Janssen Field Specialists to receive, use, and disclose my Protected Health Information for the following purposes, as applicable:

(i) contact me about and be contacted by Janssen Field Specialists;

(ii) provide me with educational and adherence materials, information, and support related to my Janssen medication (including reimbursement, access, disease awareness and product information) through Janssen Field Specialists; and

(iii) speak and otherwise communicate on my behalf with my Healthcare Providers and Janssen regarding access to, reimbursement for and fulfillment of my Janssen medication, and to confirm to my Physician that support has been provided by a Janssen Field Specialist; and

(iv) improve, develop, evaluate, and manage the Janssen Field Specialists and patient support programs.

I understand that this authorization is separate and apart from any other authorization I have provided to Janssen, including any authorization for the receipt of support from Janssen CarePath, and that cancelling one patient authorization does not affect the other. I understand that information regarding my receipt of support from Janssen Field Specialists may be shared with my Healthcare Providers. Furthermore, I understand that my Protected Health Information will not be used or disclosed by Janssen for any other purpose unless permitted by law or unless information that specifically identifies me is removed. I understand that Janssen 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. For additional information on how Janssen collects, uses, and discloses personal information visit http://janssen.com/us/privacy-policy.

I understand that I am not required to sign this Form. My choice about whether to sign will not change the way my healthcare providers treat me. If I do not sign the Form, or revoke my authorization later, I understand that this means I will not be able to participate in the receipt of information provided by Janssen Field Specialists.

This authorization will remain in effect until one year from the date of signature or until I am no longer receiving information from Janssen Field Specialists, whichever is earlier. I understand that I may revoke this authorization at any time by mailing a letter requesting such revocation to:

Nurse Navigator from Janssen CarePath
500 Atrium Drive, 3rd Floor
Somerset, NJ 08873

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. I understand the revocation of my authorization has no effect on uses and disclosures of Protected Health Information by Janssen prior to receiving my revocation notice. My authorization will also end if support from Janssen Field Specialists is discontinued. I understand that I may request a copy of this authorization.

Please see the accompanying full Prescribing Information and Medication Guide for STELARA® and discuss any questions you have with your doctor.

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