Benefit Investigation and Prescription Form

For assistance, call 877-CarePath (877-227-3728), Monday-Friday, 8:00 a.m.-8:00 p.m., ET

Once the physician has made the treatment decision to prescribe STELARA®, use the enclosed form to provide information regarding your patient’s coverage of the single IV induction dose as well as the maintenance subcutaneous doses of STELARA®. Once completed, submit the form to Janssen CarePath for benefit investigation and/or prescription of STELARA®.

Fax number is available at the top of the form.

SECTION 1

1. PRESCRIPTION INFORMATION

Prescriber information is required. Please fill out in full. Following the ordering, please have all required fields on the form included.

SECTION 2

Complete this section if the patient has NOT received the single IV induction dose. If the patient has already received the single IV induction dose, skip to Sections 6-8.

SECTION 3

Used for subcutaneous therapy. Complete this section if the patient has already received the single IV induction dose.

SECTION 4

Prescriber information is required. Please fill out in full. Following the ordering, please have all required fields on the form included.

SECTION 5

Complete the section if the patient has returned the single IV induction dose if the prescriber has already received the single IV induction dose, skip to Sections 6-8.

SECTION 6

If you wish to receive Prior Authorization Form Assistance or Status Monitoring.

SECTION 7

If you have a preferred specialty pharmacy, please note the name and phone number. If your preferred specialty pharmacy is not covered by the patient’s plan, Janssen will fax your prescription to the first pharmacy that is covered by the patient’s plan. If you do not have a preferred specialty pharmacy, leave blank.

SECTION 8

For authorization support is automatically provided with the benefit investigation if applicable; however, you may OPT OUT by checking the box in this section. If you have any questions or need assistance filling out this form, call Janssen CarePath at 877-227-3728.

Helpful Hints

- Please DO NOT use the prescriber signature stamp. Actual signatures are required.
- If required by your state, fax the state-specific blank (an actual script) at the same time you fax this form.
- Please DO NOT use the prescription stamp. Actual signatures are required.

- If you are requesting benefit investigation only for the single IV induction dose, please skip this section.

- If you have a preferred specialty pharmacy, please note the name and phone number. If your preferred specialty pharmacy is not covered by the patient’s plan, Janssen will fax your prescription to the first pharmacy that is covered by the patient’s plan. If you do not have a preferred specialty pharmacy, leave blank.

- Please DO NOT be sure to fill out all of the required sections.

- If you have already received the single IV induction dose, skip to Sections 6-8.

- If you are looking for an infusion center, please visit www.2infuse.com.

- Please see Indications, Important Safety Information, full Prescribing Information and Medication Guide for STELARA®, available at StelaraHCP.com.

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