Patient Assistance Enrollment Form

The information you provide will be used by Johnson & Johnson Health Care Systems Inc., our affiliates, and our service providers to determine your eligibility for and enroll you in the Johnson & Johnson Patient Assistance Program. You may withdraw your request for these services by calling 833-742-0791. Our **Privacy Policy** further governs the use of the information you provide.

To Be Completed by Patient

Fields marked with an (*) are required

1. PATIENT INFORMATION

*First Name: _____ *Last Name: _____ *Primary Phone: _____

Email: _____ *Date of Birth (*mm/dd/yyyy*): _____ *Sex: _____

*Address Line 1: _____ Address Line 2: _____

*City: _____ *State: _____ *ZIP Code: _____

*Product Name: Xaralto

This is the address that all self-administered medication will be shipped to. For a change of address, please contact 833-742-0791 and share the information with your Healthcare Provider.

2. INSURANCE INFORMATION *(Complete for all available insurance and submit copies of front and back of all insurance cards.)*

☐ I have no insurance and have checked eligibility requirements or applied to all available options for free or minimal cost insurance or other assistance.
If you were previously enrolled in a patient assistance program, please provide your patient ID #: _____

Primary Prescription Insurance (PPI): _____ PPI Prescription Card BIN #: _____ PPI Phone: _____

PPI Cardholder Name (First, MI, Last): _____ PPI Cardholder Date of Birth: _____

PPI Relationship to Cardholder: _____

PPI Policy #: _____ PPI Group #: _____

Primary Medical Insurance (PMI): _____ PMI Phone: _____

PMI Cardholder Name (First, MI, Last): _____ PMI Cardholder Date of Birth: _____

PMI Relationship to Cardholder: _____

PMI Policy #: _____ PMI Group #: _____

Secondary Medical Insurance (SMI): _____ SMI Phone: _____

SMI Cardholder First Name (First, MI, Last): _____

SMI Relationship to Cardholder: _____

SMI Policy #: _____ SMI Group #: _____

*Cardholder Employer Name: _____ *Cardholder Employer Phone: _____

*Cardholder Employer Address: _____

*Cardholder Employer City: _____ *Cardholder Employer State: _____ *Cardholder Employer ZIP Code: _____

3. FINANCIAL INFORMATION

***Total Gross Annual Income**
Entire household: $ _____

***Household Size**
Including yourself, the number of people who live in your home and are dependent on your household income: _____

(A credit check is required to confirm you meet the income eligibility. This will not impact your credit score.)

4. OPTIONAL COMMUNICATIONS

Permission for communications outside of Johnson & Johnson's patient support programs:

☐ Yes, I would like to receive communications relating to my medicine from J&J.
☐ Yes, I would like to receive communications relating to other products and services from J&J.

For privacy rights and choices specific to California, Colorado, Connecticut, Utah, Virginia, and Washington residents, please see J&J's US Supplemental Privacy Notice available at janssen.com/us/privacy-policy#supplemental

Permission for text communications:

☐ Yes, I would like to receive text messages. By selecting this option, I agree to receive text messages as allowed by this Form to the cell phone number provided below. Message and data rates may apply. Message frequency varies. I understand I am not required to provide my permission to receive text messages to participate in J&J's patient support programs or to receive any other communications I have selected. **Cell Phone Number:** _____

5. TERMS OF PARTICIPATION AND TERMS & CONDITIONS CONSENT *(Please review Terms & Conditions and Terms of Participation on pages 6-7.)*

My signature below certifies that I have provided accurate and complete information and that I have read, understood, and agree to the Terms & Conditions and Terms of Participation on pages 6-7. Your signature also allows Johnson & Johnson to perform a credit check. This will not impact your credit score.

*Print Patient Name: _____

*Patient or legally authorized representative† sign here: _____ *Date: _____

†A Legally Authorized Representative is a person authorized, under state or other applicable law, to act on behalf of the individual in making healthcare-related decisions, such as a parent, guardian, or (court-appointed) representative.

6. PATIENT AUTHORIZATION FORM CONSENT *(Please review Patient Authorization Form on pages 4-5.)*

By signing below, I certify that I have read, understand, and agree to the Johnson & Johnson Patient support program patient authorization form on pages 4-5.

*Print Patient Name: _____

*Patient or legally authorized representative† sign here: _____ *Date: _____

†A Legally Authorized Representative is a person authorized, under state or other applicable law, to act on behalf of the individual in making healthcare-related decisions, such as a parent, guardian, or (court-appointed) representative.

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

Patient support program patient authorization form

Why should I sign this Form?

This Form gives your Healthcare Providers permission to use and share your medical information with the patient support programs offered by Johnson & Johnson.

Section 1 What health information am I sharing and with whom?

I give permission for my Healthcare Providers and Insurers (eg, my health insurance plans) to share my Protected Health Information, as described on this Form.

My Protected Health Information includes information related to: my medical condition, treatment, prescriptions, and health insurance coverage

My Healthcare Providers may include: physicians, pharmacists, specialty pharmacies, other healthcare providers, and staff members at my healthcare providers' offices

I give permission to these people or groups to receive and use my Protected Health Information (collectively "J&J"):

- Johnson & Johnson Health Care Systems Inc., its affiliated companies, agents, and representatives
- Providers of other sources of funding. This includes foundations and co-pay assistance providers
- Service providers for the patient support programs. This includes subcontractors or healthcare providers helping J&J run the programs
- Service providers maintaining, transmitting, de-identifying, aggregating, or analyzing data from J&J's support programs

My Protected Health Information may be shared by J&J with these people and groups: my Insurers, my Healthcare Providers, any other people given permission to receive and use my Protected Health Information (as mentioned above), anyone I give permission to as an additional contact, and service providers who review data from J&J's patient support programs

J&J and the other groups on this Form may share information about me in 2 ways: as permitted on this Form, and if any information that identifies me is removed from what has been shared

Section 2 How can giving permission help with patient support programs and access?

I give permission to J&J to receive, use, and share my Protected Health Information to:

- See if I qualify for, sign me up for, contact me about, and provide services relating to J&J's patient support programs. This includes in-home services
- Manage J&J's patient support programs
- Give me resources and information related to my J&J medicine in connection with J&J's patient support programs. This includes educational and adherence materials
- Communicate with my Healthcare Providers about access, reimbursement, and fulfillment for my J&J medicine
- Inform my Healthcare Provider that I am enrolled in J&J's patient support programs
- Help verify and coordinate coverage for J&J medicines with my Insurers and Healthcare Providers
- Help with prescription or treatment location and associated scheduling
- Conduct analysis to help J&J evaluate, create, and improve their patient support services and products for patients prescribed J&J medicines
- Share information from J&J's patient support programs that may be useful for my care

Section 3 What should I understand before signing this Form?

I understand that:

J&J will use reasonable efforts to keep my information private. But, once my Protected Health Information is disclosed as allowed on this Form, it may no longer be protected by federal privacy laws

I am not required to sign this Form. My choice about whether to sign will not change how my Healthcare Providers or Insurers treat me. If I do not sign this Form, or cancel or remove my permission later, I understand I will not be able to participate in or receive assistance from J&J's patient support programs

The following groups may be paid by J&J for their services and data, including Protected Health Information:

- Pharmacies that dispense and ship my medicine
- Service providers for J&J's patient support programs

This Form will remain in effect 10 years from the date I signed below, except if:

- State law requires a shorter time or
- I am no longer in any patient support program from J&J

Information collected before that date may continue to be used for the purposes noted in this Form

- I may cancel the permissions given by this Form at any time by letting J&J know in writing at: J&J withMe, 2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560
- I can also cancel my permission by letting my Healthcare Providers and Insurers know in writing that I do not want them to share any information with J&J
- If I cancel my permission, it will not affect how J&J uses and shares my Protected Health Information received by J&J before my cancellation
- I may request a copy of this Form

Terms of Participation

I understand that JJHCS and third parties associated with administrating the Program on behalf of JJHCS (collectively, the "Program Administrators"):

- Reserve the right without notice to change the application form, change the Program or Program criteria, or to terminate my enrollment at any time;
- May request and obtain information about my or my family's income, including verification of my income, or my insurance coverage, including documentation of any insurance denials, and that the information may be requested from me, others acting on my behalf or third-party sources;
- May request that I re-verify my eligibility to receive medicines under the Program

I certify that:

- All the information on this form and all the documentation submitted are complete and correct, and to the best of my knowledge, I meet the eligibility requirements for the submission of the application
- I am completing this application voluntarily. I have not been directed by my insurance company or by a non-medical professional to complete this application. I have not been offered any financial or other benefit by any third party in order to seek assistance from Johnson & Johnson Health Care Systems Inc. (JJHCS) and I have not been told that any benefit will be denied or withheld (such as insurance coverage) if I do not complete this application
- I have completed this application myself or with the assistance of a legally authorized representative (such as a guardian), family member, caregiver, friend, healthcare provider, or representative of a patient organization. If such assistance was provided, I have reviewed the application before submission to JJHCS to ensure all information is accurate and true. No other third party has assisted with the completion of this application
- The product(s) provided under this patient assistance program will not be sold or traded
- I will notify the Johnson & Johnson Patient Assistance Program within thirty (30) days if there is any change in my income or health insurance coverage. This includes a change in my eligibility to participate in the Medicare program due to changes in my age or disability status or my enrollment in Medicare Part D
- I will not attempt to claim or submit any costs associated with the medicine(s) I receive under the Johnson & Johnson Patient Assistance Program to any person or entity, including my Medicare Part D plan
- I will not seek true out-of-pocket (TrOOP) credit under the Medicare Part D program for the cost of the medicine(s) I receive under this program

Terms & Conditions

You may be eligible to receive your medicine(s) from Johnson & Johnson free of charge for up to one year if you have been prescribed a medicine from J&J, have a financial hardship and have exhausted all other affordability options.

You must meet the eligibility and income requirements to qualify for the Johnson & Johnson Patient Assistance Program.

You are not eligible for free medicine from J&J if your health insurance will cover the cost of your prescribed medicine from J&J if this application is denied. Some employers, insurers, and other companies force patients to apply for medically necessary medicines from free product programs instead of covering such medicines directly and immediately through insurance, which could lead to delays in care and discriminate against lower-income patients. These types of "Assistance Diversion Programs" are generally established by companies that profit by diverting resources away from patients in need. An Assistance Diversion Program is any insurer, employer, or third-party program that withholds coverage or payment for Patient's medically necessary drug until Patient has completed an application for free product assistance. Assistance Diversion Programs are prohibited by J&J to make sure that help is available for patients with no safety net in place. Your insurer must submit a Patient Eligibility Certification form to confirm that your drug coverage is not subject to an Assistance Diversion Program.

You may not seek payment for the value of medicines from J&J received from this program from any health plan, patient assistance foundation, flexible spending account, or healthcare savings account.

Before you enroll in the patient assistance program, it is important you understand that you will be asked to provide personal information that may include your name, address, phone number, email address, financial information, and information related to your prescription medicine insurance and treatment. This information will be used by Johnson & Johnson Health Care Systems Inc. and its service providers to determine your eligibility for, enroll you in, and administer the program. The information will also be used to learn more about the people who use the program, to improve the program, and will be shared with service providers supporting the program.

If you have Medicare Prescription Drug Coverage (Part D), you must spend 4% of your gross annual household income on out-of-pocket prescription costs for yourself and/or other household members. You can provide a report from your pharmacy or an Explanation of Benefits (EOB) statement from your insurer to verify your out-of-pocket expenses for the current year. In addition, if your income is below 150% of the Federal Poverty Level (FPL), you will need to demonstrate that you are not eligible for the Low-Income Subsidy (LIS).

This program offer may not be used with any other coupon, discount, prescription savings card, free trial, or other offer. Offer good only in the United States and its territories. Void where prohibited, taxed, or limited by law. Program terms will expire at the end of each calendar year and may change or end without notice, including in specific states.

You may end your participation in the program at any time by calling 833-742-0791, Monday through Friday, 8:00 AM to 8:00 PM ET.

Johnson&Johnson