RemiStart® & Extended Access 2014 PATIENT ENROLLMENT FORM

Patient Rebate Program for REMICADE® (infliximab) — RemiStart® Extended Access Program for REMICADE®

☐ REMISTART® ☑ EXTENDED ACCESS **www.RemiStart.com** **Phone: 1-888-ACCESS-1 (1-888-222-3771) Fax: (877) 234-3048**

PATIENT INFORMATION	PATIENT NAME Sean Ahrens		
DATE OF BIRTH 04 / 28 / 86	GENDER: ☑ MALE ☐ FEMALE	E-MAIL seanahrens@gmail.com	
HOME PHONE (415) 633-6234	WORK PHONE ( )	If you're unavailable when we call, is it ok for us to leave a message including the prescription name, REMICADE®? ☑ YES ☐ NO	
MAILING ADDRESS 3491 20th St. #10	CITY San Francisco	STATE CA	ZIP CODE 94110

1. Do you currently have commercial or private health insurance that covers a portion of your prescription drug cost for REMICADE®?
☑ YES ☐ NO

2. Do you certify that you are NOT enrolled in any federal or state subsidized healthcare program that covers a portion of your prescription drug costs, including Medicare, such as Medicare Part D prescription drug benefit, Medicaid, TRICARE, or any other federal or state healthcare plan, including pharmaceutical assistance programs?
☑ YES ☐ NO

3. Do you certify that you will not seek reimbursement for REMICADE® from any third party payer such as a flexible spending account, a healthcare savings account or a health reimbursement account?
☑ YES ☐ NO

By submitting this form, I am requesting to be enrolled in the RemiStart® Patient Rebate Program or the RemiStart® Extended Access Program (the "Program") for REMICADE® (infliximab). I understand that my personal information will be used by Janssen Biotech, Inc., including other affiliates and companies that work on their behalf (the "Companies"), in connection with the Program, to help me get assistance with the costs of my REMICADE® therapy, or as otherwise required or allowed under the law. *I also understand that the Companies may use my name and contact information for market and outcomes research and to improve the information that the Companies provide to patients who are being treated with REMICADE®.* I understand that the Companies may de-identify my information and use or disclose the de-identified information for any purpose permitted by law. I understand that they will take commercially reasonable efforts to keep my information private.

I understand that the Companies may contact me by telephone, postal mail, or e-mail (if I provide an e-mail address) in connection with my enrollment in the Program. I understand and agree that by enrolling in the Program I may also enroll in the care coordination services provided by the AccessOne® Program, a Janssen Biotech, Inc., support system for REMICADE® and other Janssen Biotech, Inc., products. If I choose to participate in care coordination, these services may include providing educational materials related to my therapy and making reminder calls prior to and following my infusion dates. AccessOne® will also contact my doctor as necessary to administer these services.

I understand that my doctor or I will need to submit my Explanation of Benefits (EOB) to the Program following each infusion. The Program will use this information to determine the amount of costs for REMICADE® that Janssen Biotech, Inc., will reimburse. That amount will be credited to my Remistart MasterCard® Debit Card. I further understand that if my doctor or I do not submit an EOB, the Program cannot process my rebate request. I also understand that AccessOne® and the Program will share Program related information with my doctor and Preferred Site of Infusion.

I understand that I can get out of the Program at any time by notifying RemiStart®. I understand that, if I am enrolled into the Program, Janssen Biotech, Inc., will not be responsible for lost or stolen debit cards or for any misuse of these debit cards.

Fax or mail this completed enrollment form to RemiStart®: Fax: (877) 234-3048 Mail: RemiStart® • 14001 Weston Parkway, Suite 103 • Cary, NC 27513

My signature below certifies that I have completed all of the above sections completely, accurately, and to the best of my knowledge, and that I have read, understand, and agree to the Patient Authorization to release my Protected Health Information as indicated on the reverse side of this form, including but not limited to spoken or written facts about my health and payment benefits that I may have. It can include copies of records from my healthcare providers or health plans about my health or healthcare. I understand, accept, and comply with all requirements and restrictions described in the eligibility requirements provided on the back of this form and I understand that redeeming this rebate is consistent with the requirements of my health plan.

Patient Signature _____ **Date** 11/4/14 **Patient Name** Sean Ahrens
If the patient cannot sign, patient's personal representative must sign below (Please print)

Patient Name _____ **By** _____
(Signature of person signing for patient)

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

PHYSICIAN INFORMATION	☐ My office would not like to receive any fax or mail correspondence from RemiStart® regarding patient status in the program.	☐ This patient is billed directly by a Specialty Pharmacy Provider for REMICADE®	☐ My office does not accept MasterCard®
PHYSICIAN'S NAME			
SITE NAME	OFFICE CONTACT		
ADDRESS	CITY	STATE	ZIP CODE
PHONE ( )	FAX ( )		
PHYSICIAN SPECIALTY	PHYSICIAN TAX ID #	PHYSICIAN NPI #	

PREFERRED SITE OF INFUSION
(Fields below do not need to be completed if information is the same as Physician Information)

☐ Prescribing MD's office ☐ Non-prescribing MD's office ☐ Hospital outpatient ☐ Home Infusion/Infusion Provider Company ☐ Other

☐ My office would not like to receive any fax or mail correspondence from RemiStart® regarding patient status in the program.

NAME OF PHYSICIAN OR INFUSION PROVIDER	PHYSICIAN SPECIALTY	SITE NAME
ADDRESS		
CITY	STATE	ZIP CODE
PHONE ( )		
FAX ( )		
OFFICE CONTACT		
PHYSICIAN TAX ID #	PHYSICIAN NPI #	

By signing below, I hereby attest that REMICADE® is clinically appropriate for the patient listed above. I understand that my signature below does not constitute an endorsement of the RemiStart® program. I also understand that in order to manage this program, the Companies working on Janssen Biotech's behalf, in connection with the Program, may contact me to verify information about my patient's treatment with REMICADE® specific to this patient rebate program.

Physician signature _____ Date _____

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

Please read accompanying Medication Guide and full Prescribing Information for REMICADE® and discuss them with your doctor.

Patients must read this and sign the acknowledgment on the reverse side before they can participate in the Program.

My signature on the reverse side of this form confirms that I allow my doctor(s), any other healthcare providers, specialty pharmacy providers, and my health plan or insurers to share medical information relating to my use or potential use of REMICADE® (infliximab) with Janssen Biotech, Inc., including other affiliate and companies that work on their behalf, in connection with the Program (the "Companies").

The Companies administer AccessOne® and RemiStart® (the "Program") for Janssen Biotech, Inc., marketer of REMICADE®.

This information can include spoken or written facts about my health and payment benefits I may have. It may include copies of records from my healthcare providers or health plans about my health or health care.

The Companies may use and share this information to help find alternate funding sources for REMICADE®, and perform other related services. The Companies may also share my information with other related parties of this program or as otherwise set forth above.

The Companies will use and share this information to see if I qualify for the Programs and to run the Programs. In addition, the Companies may use and share my information to refer me to other programs, foundations, or alternate sources of funding or coverage that may be available to provide assistance to me with costs of my medication. Program management employees of the Companies may also see my information, but they may use it only in connection with the Program, to help me get assistance with the costs of my medication, or as otherwise required or allowed under the law. I understand that they will make every effort to keep my information private, but if it is accidentally shared with an associated party, federal privacy laws will not protect it.

This Authorization will last until I am no longer participating in the Program. 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 AccessOne® and RemiStart® (Janssen Biotech, Inc., and other affiliates and companies that work on their behalf, in connection with the Program), but will not change any information shared before I notified them of my desire to discontinue. I know that I have a right to see or copy the information my healthcare providers or insurers have given to the Companies.

I understand that I am not required to sign this form on the reverse side. My choice about whether to sign this form will not change the way my healthcare providers or insurers treat me. If I refuse to sign on the reverse side of this form, I know that this means I will not be able to receive assistance from the Program.

A copy of this signed Patient Authorization must be provided to the patient.

Patient Eligibility Requirements for the RemiStart® Program

RemiStart® is available to patients who:

- Are beginning or are currently receiving treatment with REMICADE®
- Currently have commercial insurance that covers medication costs for REMICADE®

RemiStart® Extended Access is available to patients who:

- Have exhausted their 12 months in the RemiStart® Program
- Currently have commercial insurance that covers medication costs for REMICADE®

Other Restrictions:

- This offer may not be combined with any other coupon, discount, prescription savings card, free trial, or other offer
- This program is not available to individuals enrolled in federal or state subsidized healthcare programs that cover prescription drugs, including Medicare, such as Medicare Part D prescription drug benefit, Medicaid, TRICARE, or any other federal or state healthcare plan, including pharmaceutical assistance programs. Participants certify that they will not seek reimbursement or compensation from any of these programs, to include a flexible spending account, a Health Savings Account (HSA), or a Health Reimbursement Account (HRA)
- The selling, purchasing, trading, or counterfeiting of this card is prohibited
- Offer good only in the U.S. and Puerto Rico. Janssen Biotech, Inc. reserves the right to rescind, revoke, or amend this offer without notice at any time. Void where prohibited, taxed, or otherwise restricted by law
- This program is not retroactive

How can I enroll?

1. Review the eligibility requirements above. Complete and sign the other side of this form, and make sure you obtain your doctor's signature.
2. Fax or mail this enrollment form to RemiStart®
   Fax: (877) 234-3048 Mail: RemiStart®, 14001 Weston Parkway, Suite 103, Cary, NC 27513

NOTE: Your signature on the opposite side of this form certifies:

- That you understand, accept, and comply with all requirements and restrictions described above, and that redeeming this rebate is consistent with the requirements of your health plan.
- That you have read, understand, and agree to the Patient Authorization to release your Protected Health Information as indicated above, including but not limited to spoken or written facts about your health and payment benefits you may have. It can include copies of records from your healthcare providers or health plans about your health or healthcare.

Please read the enclosed Product Information, including Boxed Warnings and Medication Guide, for REMICADE® also available at www.Remicade.com.