

Thank you for downloading this prescription assistance document from NeedyMeds. We hope this program will help you get the medicine you need.

REMEMBER — Send your completed application to the address on the form, NOT to NeedyMeds.

Did you know that NeedyMeds has thousands of other free resources?

Here's a look at more ways we can help you save money on medicine and healthcare costs. Each one can be found under the "**Healthcare Savings**" tab on our website:

- **Diagnosis-Based Assistance** — NeedyMeds lists thousands of assistance programs for almost any health condition. If you are going through chemo treatment for cancer, there are programs that can help with wig costs and scalp-cooling products. We also list resources for free diabetes testing supplies, caregiver lodging support, and much more.
- **Free, Low-Cost, and Sliding Scale Clinics** — This popular collection contains information on 18,000+ free, low-cost, and sliding scale medical, dental, mental health and substance abuse clinics across the U.S. It's a great resource if you need affordable medical treatment and don't know where to go.
- **Coupons, Rebates & More** — You can use the NeedyMeds website to find 2,600+ cost-saving opportunities for both prescription and over-the-counter drugs and medical supplies.
- **Medical Transportation** — Need help getting to the doctor's office or medical facility? You may be eligible for financial assistance if you meet certain requirements.

NeedyMeds also offers information on diagnosis-based camps and retreats, recreational programs, scholarships, government programs, \$4 generic drug programs, and more.

Finally, I want to tell you about the NeedyMeds Drug Discount Card. Thousands of people use this free, anonymous, and easy-to-use tool to get the best price on their medications. Use the card to get discounts on lab tests and also to save 40% on durable medical equipment. To date, our drug discount card has saved patients over \$300,000,000. Check out the following page to learn more.

Feel free to call our toll-free helpline if you have any questions. We can be reached at 1-800-503-6897 Monday-Friday, 9am-5pm Eastern Time.

Thank you for using NeedyMeds. Please let us know if we can do anything else to help you afford the costs of your healthcare.



Rich Sagall, MD
President, NeedyMeds

Clip the card and save



DRUG DISCOUNT CARD

BIN: 020750
RX PCN: NMeds
RX GRP: PDFPDF
ID: NMNA019309901930

Customer Care
1-888-602-2978

This is a drug discount program, not an insurance plan.

NeedyMeds Drug Discount Card
www.needymeds.org

Patient: You may use this card at any of over 65,000 participating pharmacies to save on all prescription medicines. You cannot use this card with Medicare including part D, Medicaid, or any other state or federal programs unless you choose not to use your government-sponsored program. In addition, you cannot use this card with any health insurance program, but you can use it in place of your insurance if the card offers a better price. For questions call 1-888-602-2978 or visit www.drugdiscountcardinfo.com.

Pharmacist: Administered by Medical Security Company, LLC, Tucson, AZ.

Pharmacy Help Desk: 1-800-404-1031.



- Save up to 80% on medications*
- Use at over 65,000 pharmacies nationwide including all major chains
- Share the card with friends and family

- Use the card as often as needed
- Free, no fees or registration
- Never expires

What will receive a discount?

All prescription medications are eligible for savings, including over-the-counter medicines and medical supplies written as a prescription, as well as human-equivalent pet medications with a prescription by a veterinarian.

Save up to 40% off durable medical equipment, including canes, crutches, splints, incontinence supplies and more. You can also save on diabetic supplies such as glucose meters, test strips, lancets and diabetic shoes. Visit www.needymeds.org/dme to learn more.

You can also save an extra 5% on affordable lab tests and online results. No doctor's order or insurance needed. Visit www.needymeds.org/L2L for more information.

What if I have insurance?

Anyone can use the card, but it can't be combined with state or federal insurance. You can use the card instead of insurance if:

- A drug isn't covered by your insurance
- Your insurance has no drug coverage
- You have a high drug deductible
- You have met a low medicine cap
- The card offers a better price than your copay
- You are in the Medicare Part D donut hole

To obtain a plastic drug discount card, send a self-addressed, stamped envelope to:

NeedyMeds Drug Discount Card
50 Whittemore St.
Gloucester, MA 01930

The card is not valid in combination with insurance plans, including Medicare, Medicaid or any state or federal prescription insurance. The card can be used only if you decide not to use your government-sponsored drug plan for your purchases.

* Average savings of 60%, with potential savings of up to 80% or more (based on 2018 national program savings data). All prescription medications are eligible for savings.

This is a drug discount program, not an insurance plan. Discounts are available exclusively through participating pharmacies. The range of the discounts will vary depending on the type of prescription and the pharmacy chosen. This program does not make payments directly to pharmacies. Users are required to pay for all prescription purchases. Cannot be used in conjunction with insurance. You may call 1-888-602-2978 with questions or concerns or to obtain further information.

Patient Assistance Program Application

PATIENT CHECKLIST FOR SUBMITTING AN APPLICATION

- Read the Patient Declaration and Patient Authorization to Share Health Information on page 4, then complete all relevant patient information on page 2, and **sign and date** as required
- Include a copy of the **front and back** of your insurance card
- Proof of income** (Choose one): Check the box in Section 4 on page 2 **OR** Include a copy of your most recent 1040 or 1040-SR Federal tax return
- Ask your Healthcare Professional (HCP) to complete, and **sign and date** page 3
- Submit completed pages **2 and 3 only** with documentation to:
 - Mail:** Johnson & Johnson Patient Assistance Foundation, Inc.
Patient Assistance Program
PO Box 0367, Chesterfield, MO 63006
 - Fax:** 888-526-5168 (toll free) / 740-966-1797 (direct dial)

Missing information and/or required documents may delay processing of application.

If you have questions about Johnson & Johnson Patient Assistance Foundation, Inc. (JJPAF) or how to complete this form, please contact us at 1-800-652-6227, 9am – 6pm EST, Monday through Friday.

MEDICATIONS AVAILABLE THROUGH THE PATIENT ASSISTANCE PROGRAM**Medications shipped to the patient's residence**

BALVERSA[®] (erdafitinib) Tablets
ERLEADA[®] (apalutamide) Tablets
IMBRUVICA[®] (ibrutinib) Capsules or Tablets
ZYTIGA[®] (abiraterone acetate) Tablets

Medications shipped to the HCP's office

DARZALEX[®] (daratumumab) Injection for intravenous infusion
DARZALEX FASPRO[®] (daratumumab and hyaluronidase-fihj), Injection for subcutaneous use
HALDOL[®] Decanoate* (haloperidol decanoate) Injection for extended-duration for effect
INVEGA HAFYERA[™]** (paliperidone palmitate) Extended-release Injectable Suspension
INVEGA SUSTENNA[®]** (paliperidone palmitate) Extended-release Injectable Suspension
INVEGA TRINZA[®]** (paliperidone palmitate) Extended-release Injectable Suspension
MONOVISC[®] (high molecular weight hyaluronan) Injection
ORTHOVISC[®] (high molecular weight hyaluronan) Injection
REMICADE[®]** (infliximab) Intravenous Infusion
RISPERDAL CONSTA[®]** (risperidone) Long-acting Injection
RYBREVANT[™] (amivantamab-vmjw) Injection, for intravenous use
SIMPONI ARIA[®]** (golimumab) Intravenous Infusion
STELARA[®]† (ustekinumab) Injection, for subcutaneous or intravenous use
TREMFYA[®] (guselkumab) Prefilled syringe or One-Press patient-controlled injector
YONDELIS[®] (trabectedin) Injection for intravenous infusion

Medications available through retail or specialty pharmacy. HCP must provide a prescription.

CONCERTA[®]** (methylphenidate HCl) Extended-release Tablets CII
EDURANT[®] (rilpivirine) Tablets
ELMIRON[®] (pentosan polysulfate sodium) Capsules
INTELENCE[®] (etravirine) Tablets
INVOKAMET[®]** (canagliflozin/metformin HCl) Tablets
INVOKAMET XR[®]** (canagliflozin/metformin HCl) Extended-release Tablets
INVOKANA[®] (canagliflozin) Tablets
PONVORY[™] (ponesimod) Tablets
PREZCOBIX[®] (darunavir 800mg/cobicistat 150mg) Tablets
PREZISTA[®] (darunavir) Tablets or Oral Suspension
PROCRT[®]** (epoetin alfa) Injection, for subcutaneous or intravenous use
SIMPONI[®]** (golimumab) SmartJect[®] or Prefilled syringe
SIRTURO[®]** (bedaquiline) Tablets
SPORANOX[®]** (itraconazole) Capsules or Oral Solution
SPRAVATO[®]** (esketamine) Nasal Spray CIII, for intranasal use
STELARA[®]† (ustekinumab) Injection, for subcutaneous or intravenous use
SYM TUZA[®]** (darunavir, cobicistat, emtricitabine, and tenofovir alafenamide) Tablets
TREMFYA[®] (guselkumab) Prefilled syringe or One-Press patient-controlled injector
XARELTO[®]** (rivaroxaban) Tablets

*Please read full Prescribing Information, including Boxed Warning.

†May be distributed via pharmacy or shipped to HCP.

The Johnson & Johnson Patient Assistance Foundation, Inc. (JJPAF) is an independent, non-profit organization that is committed to helping eligible patients without insurance coverage receive prescription products donated by Johnson & Johnson operating companies.

You may be eligible for our free prescription program for up to one year if you meet the requirements below:

- You have been prescribed a Johnson & Johnson operating company donated medication
- You meet the eligibility income requirements for the medication(s)
- You don't have insurance **or** medicine is not covered
 - Some patients with Medicare Prescription Drug Coverage (Part D) who cannot afford their medicines and who meet certain financial criteria may also be eligible for assistance. A report from your pharmacy or an Explanation of Benefits (EOB) statement from your insurer that shows your out-of-pocket costs for the current year can be requested and may be submitted with your application. In order to qualify for the program, you must spend 4% or more of your gross annual income on prescription drugs.
- You live in the United States or a U.S. territory
- You are being treated by a U.S. licensed doctor as an outpatient

Patient Assistance Program Application

TO BE COMPLETED BY THE PATIENT See checklist on page 1—all information is required.

1 Patient Information

Name: _____ Phone: _____ Email: _____
 Social Security #: _____ Date of Birth: _____ Gender: Male Female
 Address (Street, City, State, ZIP): _____

2 Financial Information

Federal Taxes (Select one of the options below **ONLY** if you do not check the box in Section 4)
 A copy of my most recent 1040 or 1040-SR Federal tax return is attached. (Not required for SIRTURO** applications.)
 I do not file Federal taxes. (Tax returns may be reviewed and additional documentation requested.)

Total Gross Yearly Income
 Entire household: \$ _____

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

3 Healthcare Insurance Information (Select all that apply.) **Please provide copies of front and back of all medical and prescription insurance cards.**

Subscriber Name: _____ Date of Birth: _____ Relationship to Patient: _____
 Primary Plan Name: _____ Secondary Plan Name: _____

<input type="checkbox"/> Check if no insurance	ID/Policy #	Group #	Phone
<input type="checkbox"/> Prescription Insurance/Medicare Part D Plan Plan Name: _____ Fax: _____ Rx BIN #: _____ Rx PCN: _____			
<input type="checkbox"/> Private/Commercial Insurance			
<input type="checkbox"/> Medicaid			
<input type="checkbox"/> Medicare Part B			
<input type="checkbox"/> Medicare Advantage			
<input type="checkbox"/> Veterans Administration			
<input type="checkbox"/> ADAP AIDS			
<input type="checkbox"/> SPAP State Patient Assistance Program			
<input type="checkbox"/> Other:			

4 Patient Declaration/Authorization to Assign Representative for Program Enrollment

Signature and date required before submission.

My signature below indicates that I have read, understand, and agree to the Patient Declaration and Patient Authorization to Share Health Information on page 4. If I have listed an authorized representative below, I permit the Johnson & Johnson Patient Assistance Foundation, Inc. (JJPAF) to discuss my application with this person. This includes the status of my application, insurance and financial questions, any missing documentation, and other issues related to my application and participation, throughout my enrollment period in the program. By signing below, this representative is allowed to speak on my behalf regarding my application with JJPAF.

CHECK THE BOX:	▶	<input type="checkbox"/>	<p>Applicant Financial Verification Authorization</p> <p>I also understand that JJPAF and the vendors associated with administering the Program (collectively the “Program Administrators”) may obtain a credit report or investigative credit report about me which may contain information as to my income or credit standing, to determine my eligibility for the Program. I hereby authorize such credit report and income verification and acknowledge that such authorization extends to consumer reporting agencies and to subsequent reports for purposes of determining my eligibility for the JJPAF Program.</p>
PLEASE COMPLETE, SIGN & DATE:	▶	<p>Patient Name (print): _____ Date: _____</p> <p>Authorized Representative Name (print if applicable): _____</p> <p>Relationship to Patient (print if applicable): _____ Phone: _____</p> <p>_____ Date: _____</p> <p>Patient Signature/Authorized Representative</p>	

*Please read full Prescribing Information, including Boxed Warning.
 Revised: August 2021

Patient Assistance Program Application

TO BE COMPLETED BY THE HEALTHCARE PROFESSIONAL (HCP)—all information is required.

1 Prescription *(If requesting more than 1 product, attach additional prescription information.)*

Patient Name: _____ Date of Birth: _____

ICD Code *(HCP-administered products only)*: _____

Name of Product: _____

Strength: _____ Sig: _____

Quantity: _____ Days' Supply: _____ Number of Refills *(maximum 11)*: _____

BALVERSA®, ERLEADA®, IMBRUVICA®, or ZYTIGA®:

- If you are a prescriber in New York, South Carolina, or Washington and are requesting BALVERSA®, ERLEADA®, IMBRUVICA®, or ZYTIGA®, you must attach prescription on your state official prescription form with this application.

BALVERSA®, ERLEADA®, IMBRUVICA®, or ZYTIGA®:

- List any patient allergies:
 _____ or NKDA

BALVERSA®, ERLEADA®, IMBRUVICA®, or ZYTIGA®:

- List patient's current medications:
 _____ or none

BALVERSA®:

- Has the patient tested positive for FGFR? Yes No

HIV Medication:

- Check if patient is currently taking: PREZISTA® PREZCOBIX®
 INTELENCE® EDURANT® SYMTUZA®*

PROCRIT®*:

- Hemoglobin level based on most recent lab results: _____
- Required: Is the patient being treated on renal dialysis? Yes† No

RYBREVA™:

- Has the patient tested positive for EGFR exon 20 insertion mutation?
 Yes No

Select STELARA® Distribution Option (must select one):

- Ship to HCP's office
- Retail or specialty pharmacy. HCP must provide a prescription.

Select TREMFYA® Distribution Option (must select one):

- Ship to HCP's office
- Retail or specialty pharmacy. HCP must provide a prescription.

2 HCP Information

Name: _____ Site Name: _____

Site Contact: _____ Business Hours: _____

Address *(Street, City, State, ZIP)*: _____

Phone: _____ Fax: _____ Email: _____

Tax ID #: _____ NPI # *(required)*: _____

State License # *(required)*: _____ Expiration *(mm/yyyy)*: _____ DEA # *(required)*: _____

Collaborating MD *(for mid-level providers)*: _____ Collaborating MD NPI # *(required)*: _____

Provider Transaction Access Number (PTAN) *(required if the patient has Medicare)*: _____

HCP Distribution Shipping Address or SPRAVATO® REMS-Certified Treatment Center Address (if different from above):

Site Name: _____ Contact Name for Shipment: _____

Business Hours: _____ Phone: _____ Fax: _____

Address *(Street, City, State, ZIP)*: _____

Please note, Florida HCPs may be required to provide Florida Pedigree information at time of first shipment.

3 HCP Authorization

My signature below indicates that I have read, understand, and agree to the Johnson & Johnson Patient Assistance Foundation, Inc. policy and the terms of Program participation on page 5.

HCP SIGN & DATE:	Healthcare Professional Signature	Date: _____
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*Please read full Prescribing Information, including Boxed Warning.

†Contact Amgen Inc. 1-800-772-6436.

Patient Assistance Program Application

PATIENT DECLARATION AND PATIENT AUTHORIZATION TO SHARE HEALTH INFORMATION

Please read, sign and date on page 2, Patient Section 4.

I promise:

- The information on this form is correct and complete including all copies of documents proving my income.
- The product(s) provided under this patient assistance program will not be sold or traded.
- I will notify the Johnson & Johnson Patient Assistance Foundation, Inc. (JJPAF) Patient Assistance Program ("Program") within thirty (30) days if there is any change in the status of my eligibility (related to changes in income or health coverage) to receive products through this program. 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.
- Not to attempt to claim or submit any costs associated with the medicine(s) I receive under the Johnson & Johnson Patient Assistance Foundation, Inc. Patient Assistance Program to any person or entity, including my Medicare Part D plan.
- Not to 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.

I authorize the following communications:

- Specifically, I authorize JJPAF to contact me to request my assistance with analysis related to the quality and efficacy of the JJPAF Program.
- When signing this application, I am agreeing to allow the manufacturer or its agent to contact me or my healthcare provider for additional information, if needed, to evaluate any adverse event or product complaint I or my provider reported on my behalf.
- The Program to contact my insurer, other potential funding sources, including the Centers for Medicare and Medicaid Services, social workers, or patient advocacy organizations on my behalf in order to determine if I am eligible for health insurance coverage or other funds, and disclose to them information contained in my JJPAF Program application or information about my prescribed medications and medical condition that has been provided by my physician, healthcare provider, or pharmacist.

I understand that JJPAF and the vendors associated with administrating the Program (collectively the "Program Administrators"):

- Reserve the right without notice to change the application form, change the Program or Program criteria, or terminate my enrollment at any time, without notice.
- May request and obtain information about my or my family's income, including verification of my income through third-party sources.

Patient Authorization To Share Health Information: By signing on page 2, I hereby authorize:

- My doctor(s), pharmacy and other healthcare providers, and my health plan or insurers ("Entities") to disclose to and share with JJPAF, the Program Administrators and their affiliates, agents, contractors, representatives, service providers, and assignees ("JJPAF Recipients"), my individually identifiable health information, which may include my full name, demographic information, financial information, and information related to medical condition, treatment, care management, health insurance and benefits, medication history, and prescriptions (collectively, "Health Information"), whether in written or verbal form, including portions of my medical record.
- The JJPAF Recipients to access, obtain, use, disclose, receive, and maintain my Health Information for purposes of processing this Application, verifying the information provided in this Application, assisting in the identification of or determining eligibility under the Program and other patient assistance resources, investigating and verifying my insurance benefits, coordinating the dispensing and delivery of medication, and conducting the additional services described above and to run the Program, including internal business purposes.

In addition, by signing on page 2, I understand and agree that:

- I may refuse to sign the form on page 2. This authorization is voluntary, but if I refuse to sign this form, I know that this means that I may no longer be eligible to receive assistance from the Program. I understand that my doctor(s), pharmacy and other healthcare providers, and my health plan or insurers may not condition the provision of my treatment, or coverage of my benefits, on my signing this authorization.
- Health Information released under this authorization may no longer be protected by state and federal law, including the Health Insurance Portability and Accountability Act (HIPAA).
- The information provided in this application may be subject to random audits and verification, and that during such audits and verification processes, I may be asked for additional supporting documentation and will comply with such requests.
- I may withdraw my authorization at any time by mailing a written withdrawal to JJPAF at PO Box 0367, Chesterfield, MO 63006, however, such withdrawal will not have an impact on any actions that have already been taken in reliance on this authorization.
- This authorization will last until I am no longer participating in the Program or sooner as limited by applicable state law.
- I have a right to receive a copy of this authorization.

Patient Assistance Program Application

HEALTHCARE PROFESSIONAL AUTHORIZATION: JJPAF POLICY AND TERMS & CONDITIONS AGREEMENT

Please read, sign and date on page 3, HCP Section 3.

Johnson & Johnson Patient Assistance Foundation, Inc. (JJPAF) policy prohibits Healthcare Professionals (HCPs) from charging patients any fee for enrollment or other activities associated solely with the patient's participation in the Patient Assistance Program ("Program").

- JJPAF requests that HCPs not charge the patient for those professional services associated with this regimen not covered by the patient's health insurer.
- No claim may be made to any third-party payer (e.g., Medicaid, Medicare, private insurance, etc.) for payment for product provided under the Program.
- In accordance with the CMS Medicare Policy Manual, CMS will not reimburse you for any free product donated from JJPAF. In addition, in accordance with our eligibility criteria, Medicare Part B patients may receive free physician-administered product from JJPAF when such product is not covered by CMS. In such a case, and according to CMS policy, claims for administration services may not be reimbursed. You accept product from JJPAF with this understanding.
- The product(s) provided under the Program may not be sold or traded and may not be returned for credit.
- The JJPAF Program is limited to patients being treated on an outpatient basis.
- JJPAF and the vendors associated with administering the Program (collectively, the "Program Administrators") reserve the right to request additional information if needed and to change or terminate the Program at any time, without notice.
- JJPAF and the Program Administrators reserve the right to refuse to distribute the medications under this program to any patient or facility at any time, without notice.

Indicate your agreement to the terms of the JJPAF Program participation by signing on page 3. Your signature is intended to confirm to JJPAF:

- There is a valid medical need for this patient's prescription.
- I authorize JJPAF or its affiliated companies or subcontractors to forward the patient's prescription to a dispensing pharmacy on behalf of the patient.
- I authorize JJPAF to use my provider information, including National Provider ID # to determine a patient's eligibility in the Program.
- That to the best of your knowledge this patient does not have prescription drug insurance coverage for the product(s) listed above.
- For SIRTURO^{®*}, if the patient has been diagnosed with pulmonary multi-drug resistant tuberculosis (MDR-TB), appropriate notification has been made to the local (state) health department.
- For SPRAVATO^{®*}, the healthcare setting will be certified in the SPRAVATO[®] Risk Evaluation and Mitigation Strategy (REMS) and the patient will be enrolled in the SPRAVATO[®] REMS. SPRAVATO[®] will not be dispensed directly to this patient for home use.
- You are not prohibited from participating in Federally funded healthcare programs nor are you on the List of Excluded Individuals/Entities maintained by the HHS Office of Inspector General.
- That the medication(s) provided to you by the Program will not be provided or dispensed to any other person.
- I have a signed copy on file of my patient's current and completed patient authorization to share health information in accordance with HIPAA, or any other authorization or consent required by law, so that you may share patient health information with the Program, including the JJPAF Recipients.
- I understand that the information provided in this application may be subject to random audits and verification and that, during such audits and verification processes, I may be asked for additional supporting documentation and will comply with such requests.