



## PATIENT ASSISTANCE PROGRAM

To apply for assistance, please complete this application, attach the patient's most recent federal tax return and return by mail or fax.

Mail to: Patient Assistance Program, P.O. Box 221857, Charlotte, NC 28222-1857

Telephone: (800) 652-6227 Fax: (888) 526-5168

<b>Patient Information</b>	Name: _____	Guardian Name (if appropriate): _____
Address: _____		
Primary Telephone #: (____) _____		Alternate Telephone Number: (____) _____
Social Security #: _____		Date of Birth: _____ Gender: M <input type="checkbox"/> F <input type="checkbox"/>

### Financial Information

Salary/Wages/Unemployment \$: _____	SSI: \$ _____
Pension/Social Security \$: _____	SSDI: \$ _____
Other \$: _____	<b>TOTAL ANNUAL GROSS INCOME: \$ _____</b>
Household Size (Number of persons who contribute to or are dependent on patient's household income) _____	

Please check applicable box: Attached is a copy of my most recent federal tax return.  I do not file federal taxes.

Value of Assets \$ \_\_\_\_\_ Include: checking & savings accounts, certificates of deposit, stocks & bonds, mutual funds, IRAs, cash, and the value of life insurance policies if you turned in your policies for cash right now. **Not included:** your home, vehicles, burial plots or personal possessions

**Insurance Information: If the patient does not have any public or private insurance, please check this box**

<b>Medicare</b>	Is patient eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No
	If no, please check this box if patient will be eligible for Medicare within the next 12 months. <input type="checkbox"/>
	If box is checked, please provide date patient will be Medicare eligible _____ / _____ / _____ (Month/Day/Year).
	Medicare Policy # _____ Did Medicare benefits begin within the past 2 months? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Is the patient enrolled in a Medicare prescription drug plan? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Insurance Company: _____ Telephone #: _____ Plan Name/ #: _____ Policy ID #: _____
Is the patient eligible for the Low Income Subsidy for Medicare Part D? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Application Pending	
<b>Medicaid</b>	Is patient eligible for Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is the patient eligible for prescription drug benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No - Medicare Savings Program-Only (i.e., QMB, SLMB, QI-1) <input type="checkbox"/> No - Spend-down not reached
	Is patient eligible for other state/government programs that provide prescription drug benefits (i.e., SPAP - State Pharmacy Assistance Programs)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Applied <input type="checkbox"/> Not Applied <input type="checkbox"/> Application Pending <input type="checkbox"/> Waitlisted
<b>Private/ HMO</b>	Insurance Company: _____
	Telephone #: (____) _____ Policy ID #: _____ Group ID #: _____
	Subscriber Name: _____ Relation to Patient: _____ Date of Birth: _____
	Does this policy cover prescription drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No

### Applicant Declaration Regarding Change in Insurance Coverage

Johnson & Johnson Health Care Systems Inc. is a duly authorized agent for Janssen Ortho Patient Assistance Foundation "JOPAF". "I understand that JOPAF policy requires individuals with access to medicines through an affordable benefit to seek access through that benefit. As such, I promise that I will notify Johnson & Johnson Health Care Systems Inc. and its Patient Assistance Program within 30 (thirty) days by mail at Patient Assistance Program, P.O. Box 221857, Charlotte, NC 28222-1857, OR by telephone at (800) 652-6227, OR by fax at 888-526-5168, if there is any change in the status of my eligibility to obtain any drug(s) that I will receive under this Patient Assistance Program through any other resource at any time during my participation in this Patient Assistance Program. I understand that this notification requirement would apply to circumstances including, but not limited to, changes in my eligibility to participate in the Medicare program [due to changes in my age (65+) or disability status (including end-stage renal disease)], or my enrollment in the Medicare Part D prescription drug benefit."

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Applicant Declaration Regarding Accuracy and Completeness of Information

"I promise that the information on this form is correct and complete. If needed, Johnson & Johnson Health Care Systems Inc. and its Patient Assistance Program (the "Program") may request and obtain information about my or my family's income to enroll me in the Program. I understand that the Program administrators reserve the right any time and without notice to modify the application form; modify or discontinue any or all of the Program and the related eligibility criteria; or terminate assistance provided by the Program at any time."

Please indicate your agreement with these terms by signing below.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**PATIENT ASSISTANCE PROGRAM**

Please complete this form and return by mail or fax. Please note that the Program will need to receive both the patient information and physician information in order to process the application.

Mail to : Patient Assistance Program, P.O. Box 221857, Charlotte, NC 28222-1857

Telephone: (800) 652-6227 Fax: (888) 526-5168

Patient Name: \_\_\_\_\_

**2. Physician Information** Name: \_\_\_\_\_ Title: \_\_\_\_\_

Facility Name: \_\_\_\_\_ Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

Business Hours: \_\_\_\_\_ Office Contact Name: \_\_\_\_\_

Tax ID #: \_\_\_\_\_ Medicare Provider #: \_\_\_\_\_

**Pharmacy Card Distribution (Check all applicable)**

Patients receiving assistance through the Pharmacy Card will need a valid prescription from their prescribing physician to access medication at a local pharmacy.

Concerta <sup>®</sup> (methylphenidate HCl) Extended-Release Tablets CII	Duragesic <sup>®</sup> (fentanyl transdermal system) CII	Razadyne <sup>®</sup> (galantamine HBr) Tablets/Oral Solution	Razadyne <sup>®</sup> ER (galantamine HBr) Extended-Release Capsules
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**Direct to Physician Distribution (Check all applicable)**

The medication listed under the Direct to Physician Distribution will be shipped to the physician's office. Patients deemed eligible for the Program are eligible for up to twelve months of assistance as long as they continue to meet eligibility requirements. Please indicate if the shipping address is different from the physician's address. Yes  No  If YES, please provide shipping information below:

Facility Name: \_\_\_\_\_ Facility Contact Name: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Business Hours: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

Axert <sup>®</sup> (almotriptan maleate) Tablets	Haldol <sup>®</sup> (haloperidol) Injection	PolyCitra <sup>®</sup> -K (potassium citrate and citric acid for oral solution, USP)	Terazol <sup>®</sup> (terconazole) 3 Vaginal Cream or Suppositories
Biafine <sup>®</sup> Topical Emulsion	Levaquin <sup>®</sup> (levofloxacin) Tablets/Oral Solution	PolyCitra <sup>®</sup> -K Crystals (potassium citrate and citric acid for oral solution)	Terazol <sup>®</sup> (terconazole) 7 Vaginal Cream
Bicitra <sup>®</sup> (sodium citrate and citric acid oral solution, USP)	Monistat-Derm <sup>®</sup> (miconazole nitrate cream 2%)	Regranex <sup>®</sup> (becaplermin) Gel 0.01%	Topamax <sup>®</sup> (topiramate) Tablets
Centany <sup>™</sup> (mupirocin ointment), 2%	Mycelex <sup>®</sup> (clotrimazole) Troche	Retin-A <sup>®</sup> (tretinoin) Cream, Gel, Liquid or Micro	Topamax <sup>®</sup> (topiramate) Sprinkle Capsules
Diropan <sup>®</sup> (oxybutynin chloride) Tablets and Syrup	Neutra-Phos <sup>®</sup> (oral sodium and potassium phosphate mixture)	Risperdal <sup>®</sup> (risperidone) Tablets/ Oral Solution	Ultracet <sup>®</sup> (tramadol hydrochloride/acetaminophen) Tablets
Diropan <sup>®</sup> XL (oxybutynin chloride) Extended Release Tablets	Neutra-Phos-K <sup>®</sup> (oral potassium phosphate mixture)	Risperdal <sup>®</sup> (risperidone) M-TAB <sup>®</sup> Orally Disintegrating Tablets	Ultram <sup>®</sup> (tramadol HCl) Tablets
Elmiron <sup>®</sup> (pentosan polysulfate sodium) Capsules	Nizoral <sup>®</sup> (ketoconazole) Tablets	Risperdal <sup>®</sup> Consta <sup>®</sup> (risperidone) Long-Acting Injection	Ultram <sup>®</sup> ER (tramadol HCl) Extended-Release Tablets
Ertaczo <sup>™</sup> (sertaconazole nitrate) Cream 2%	Pancrease <sup>®</sup> MT (pancrelipase) Capsules	Risperdal <sup>®</sup> Consta <sup>®</sup> (risperidone) Long-Acting Injection with three week oral Risperdal <sup>®</sup> therapy*	Urispas <sup>®</sup> (flavoxate HCl) Tablets
Flexeril <sup>®</sup> (cyclobenzaprine HCl) Tablets	Parafon Forte <sup>®</sup> DSC (chlorzoxazone) Caplets	Spectazole <sup>®</sup> (econazole nitrate) Cream	
Grifulvin V <sup>®</sup> (griseofulvin tablets) Microsize and (griseofulvin oral suspension) microsize Tablets/Suspension	PolyCitra <sup>®</sup> Syrup (tricitrates oral solution)	Sporanox <sup>®</sup> (itraconazole) Capsules	
Haldol <sup>®</sup> (haloperidol) Decanoate Injection	PolyCitra <sup>®</sup> LC (tricitrates oral solution)	Sporanox <sup>®</sup> (itraconazole) Oral Solution	

**Prescribing Information - Please attach additional prescribing information for each additional drug prescribed through Physician Distribution.**

Patient Name: \_\_\_\_\_ Product Name: \_\_\_\_\_

Dosage: \_\_\_\_\_ Sig: \_\_\_\_\_ Quantity: \_\_\_\_\_

Date: \_\_\_\_\_ Number of Refills: (Maximum 12) \_\_\_\_\_ State License #: (required) \_\_\_\_\_

**\* If this patient is not currently on an oral antipsychotic medication and requires three weeks of oral Risperdal<sup>®</sup>, please attach prescribing information for both oral Risperdal<sup>®</sup> and Risperdal<sup>®</sup> Consta<sup>®</sup>. The prescription information section above may be completed for continued Risperdal<sup>®</sup> Consta<sup>®</sup> therapy extending beyond 3 weeks.**

To the best of my knowledge, this patient does not have prescription drug insurance coverage (including Medicaid, county funded, or other public programs) for the product(s) listed above. Johnson & Johnson Health Care Systems Inc. requests that physicians 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 or administration of product provided under the Program. Also, these goods may not be sold or traded and may not be returned for credit. Please indicate that you agree to these terms by signing below. Your signature confirms that there is a valid medical need for this patient's prescription.

Physician Signature: \_\_\_\_\_

Physician's DEA # (Required for Duragesic<sup>®</sup> CII and Concerta<sup>®</sup> Extended Release Tablets CII only): \_\_\_\_\_

Required for Duragesic<sup>®</sup> CII only:

"I have received a copy of the full prescribing information required for Duragesic<sup>®</sup> CII and I am prescribing this product for chronic pain."

Physician Signature: \_\_\_\_\_



PO BOX 221627 • CHARLOTTE, NC • 28223-1627 • FAX: 704.333.0265 FAX

### Authorization to Share Health Information for Patient Assistance Program

**Provider Instructions: Patients must complete this form before they can participate in the Program.**

I, \_\_\_\_\_, allow my doctor(s), any other health care providers, and my health plan or insurers to give medical information relating to my use or need for products provided under this program to Lash Group. Lash Group runs the Patient Assistance Program (the "Program") for Johnson & Johnson Health Care Systems Inc. Johnson & Johnson Health Care Systems Inc. manages the Program on behalf of its affiliates: Janssen L.P., McNeil Consumer & Specialty Pharmaceuticals (a division of McNeil-PPC, Inc.), PriCara, a unit of Ortho-McNeil, Inc., Ortho-McNeil Neurologics, Inc., Ortho Women's Health (a division of Ortho-McNeil Pharmaceutical, Inc.), Ortho Urology (a division of Ortho-McNeil Pharmaceutical, Inc.), OrthoNeutrogena (a division of Ortho-McNeil Pharmaceutical, Inc.), and Johnson & Johnson Wound Management Worldwide (a division of ETHICON, Inc.). These affiliate companies make the products that are provided in the Program.

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

Lash Group and Johnson & Johnson Health Care Systems Inc. will use and give out this information to see if I qualify for the Program and to run the Program. People who work for and with Lash Group and Johnson & Johnson Health Care Systems Inc. may also see my information, but they may use it only to help me get assistance with the costs of my drugs and to operate the Program. I understand that they will make every effort to keep my information private, but if it is accidentally given out, 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 before that time, I can tell my health care providers and my insurers in writing that I do not want them to share any more information with Lash Group or Johnson & Johnson Health Care Systems Inc., but it will not change any actions they took before I told them. I know that I have a right to see or copy the information my health care providers or insurers have given to Lash Group and Johnson & Johnson Health Care Systems Inc.

**I KNOW THAT I MAY REFUSE TO SIGN THIS FORM.** My choice about whether to sign this form will not change the way my health care providers or insurers treat me. If I refuse to sign this form, I know that this means I may no longer be able to receive assistance from the Program.

Patient Sign Here: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_  
(Print)

If the patient cannot sign, patient's personal representative must sign below:

Patient Name: \_\_\_\_\_

By: \_\_\_\_\_  
(Signature of person signing for patient)

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

A copy of this form must be provided to the patient.

February 2006

**PATIENT ASSISTANCE PROGRAM ADMINISTRATOR FOR THE PRODUCTS OF:**

