PATIENT ASSISTANCE PROGRAM

Johnson & Johnson HEALTH CARE SYSTEMS INC.

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, PO Box 221857, Charlotte, NC 28222-1857
Telephone: (800) 652-6227 Fax: (888) 526-5168

1 Patient Information

Name: _____ Guardian Name (if appropriate): _____

Address: _____

Primary Telephone #: (_____) _____ Alternate Telephone #: (_____) _____

Social Security #: _____ Gender: M ☒ F ☐

Total Annual Gross Household Income

Salary/Wages/Unemployment: $ _____

SSI: $ _____

Pension/Social Security: $ _____

SSDI: $ _____

Other: $ _____

TOTAL ANNUAL GROSS INCOME: $ 0.00

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 ☐

Insurance Information: Please provide information on all insurers, including public programs such as Medicaid, Medicare, and state, county, or other programs. If the applicant does not have insurance, please enter "No Insurance" on the first line.

Primary Insurance Company: _____ Telephone #: (_____) _____

Policy ID #: _____ Group ID # : _____

Subscriber Name: _____ Relation to Patient: _____ Date of Birth: _____

Does this policy cover prescription drugs? Yes ☐ No ☐

Does the applicant have coverage through secondary insurance, including Medicaid or Medicare? Yes ☐ No ☐ If yes, provide name, telephone and policy number: _____

Does this policy cover prescription drugs? Yes ☐ No ☐

Has the applicant applied to the following for health care coverage?

Medicaid: Yes ☐ No ☐ If YES, result: _____

Supplemental Security Income (SSI) Yes ☐ No ☐ If YES, result: _____

Social Security Disability (SSDI) Yes ☐ No ☐ If YES, result: _____

Patient Advocate Information (If different from physician)

Name: _____ Address: _____

City, State, Zip: _____ Telephone: (_____) _____ Fax: (_____) _____

Check box if all correspondence should be directed to the Patient Advocate. ☐ A Patient Advocate may be a healthcare worker involved in the patient's care – a physician, nurse, physician assistant, social worker or case manager. Friends or family members cannot act as Patient Advocates.

Patient Advocate Signature: _____ Date: _____

Applicant Declaration

"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: _____

Referral Code: (Internal Use Only)

Johnson & Johnson
HEALTH CARE SYSTEMS INC.

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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, PO Box 221857, Charlotte, NC 28222-1857

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

Patient Name: _____ Social Security #: _____

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® *(methylphenidate HCl)* Extended-release Tablets CII	Duragesic® *(fentanyl transdermal system)* CII	Razadyne™ *(galantamine HBr)* Tablets/Oral Solution	Razadyne™ *ER (galantamine HBr)* Extended-Release Capsules

Direct to Physician Distribution (Check all applicable)

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

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

Patient Name: _____ Product Name: _____

Dosage: _____ Sig: _____ Quantity: _____

Number of Refills: (Maximum 12) _____ **State License #: (required)** _____ Date: _____

***If this patient is not currently on an oral antipsychotic medication and requires three weeks of oral Risperdal®, please attach prescribing information for both oral Risperdal® and Risperdal® Consta®. The prescription information section above may be completed for continued Risperdal® Consta® 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® CII and Concerta® Extended-release Tablets CII only): _____

Required for Duragesic® CII only:

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

Physician Signature: _____

April 2005

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HEALTH CARE SYSTEMS INC.
PATIENT ASSISTANCE PROGRAM
PO BOX 221857 • CHARLOTTE, NC • 28222-1857 • FAX: 1-888-526-5168

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 Pharmaceutica Products, L.P., McNeil Consumer & Specialty Pharmaceuticals (a division of McNeil-PPC, Inc.), Janssen Ortho-McNeil Primary Care, 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: _____

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.