RISPERDAL® (risperidone) PATIENT ASSISTANCE PROGRAM

The following information is required to enable the Patient Assistance Program specialists to determine eligibility for a patient. If eligibility is established, the **original form** with signature must be sent to the address below before product can be shipped.

Mail: Risperdal Patient Assistance Program
PO Box 222098
Charlotte, NC 28222-2098

Telephone: (800) 652-6227 Fax: (888) 526-5170

New Application ☑ Re-application ☐

PATIENT INFORMATION (Please Print Clearly)

Patient Name: JOHN DOE

Name of Guardian (if appropriate):

Street Address: 123 SOUTH STREET

City, State Zip: L.A., CA 900000000

Telephone: Day (123) 456 6789 Evening (____) ___ - _____

SS#: 123 / 45 / 9876 M ☑ F ____

HEALTH INSURANCE INFORMATION

Primary Insurance

Health Insurance Company: SEE ATTACHED PFI

Telephone:
(_____)_____

Policy ID Number: _____ Group ID Number: _____

Subscriber Name: _____ Date of Birth: _____

Subscriber's Relation to Patient: _____

Are you covered by secondary insurance, including Medicaid or Medicare?
☐ YES ☐ NO
(If yes, please provide name, telephone number, and policy number.)

Do these policies cover prescription drugs? ☐ YES ☑ NO

Public Programs

Have you applied to any of the following for health coverage?

Medicaid: ☑ YES ☐ NO
Result: PENDING

Supplemental Security Income (SSI): ☑ YES ☐ NO
Result: PENDING

Social Security Disability (SSDI): ☐ YES ☑ NO
Result: _____

FINANCIAL INFORMATION

Gross Annual Household Income and Source of Income:

Salary/Wages/Unemployment	$ SEE ATTACHED PFI
Pension/Social Security	$
SSI	$
SSDI	$
Other: _____	$
Total	$

Number of household members dependent on income stated above (include applicant) _____

PLEASE CHECK APPLICABLE BOX

Attached is a copy of my most recent federal tax return.*	
I do not file federal taxes.	✔

***Required on initial applications and annually thereafter.**

APPLICANT DECLARATION

"I promise that the information on this form is correct and complete. If needed, Janssen Pharmaceutica Products, L.P. and its RISPERDAL® 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 SSSSSSSSSSSSSS

Date 1-23-4567

PHYSICIAN INFORMATION

Physician Name: X. DOE, M.D.

Facility Name LONG BEACH MENTAL HEALTH

Street Address 1975 LONG BEACH BLVD.

City, State Zip: LONG BEACH, CA 90806

Tel: (123) 456-7890

Fax: (123) 654-0987

Business Hours:

Office Contact Name: MARY SMITH

PRODUCT DISTRIBUTION INFORMATION

Indicate shipping address if different from above address. (Please provide facility name, address, telephone, and contact person).

550 SO. VERMONT, ROOM 903
LOS ANGELES, CA 90020

PRODUCT DESCRIPTION

Indicate Product requesting assistance for:

☑ Risperdal® **(risperidone)** Tablets
☐ Risperdal® **(risperidone)** Oral Solution
☐ Risperdal® **(risperidone)** M-TAB™
☐ Risperdal® **(risperidone)** CONSTA™
☐ Risperdal® **(risperidone)** CONSTA™ **with three week oral Risperdal® therapy***

***If this patient is not currently on an oral antipsychotic medication and requires three weeks of oral Risperdal®, please attach a separate Rx for the prescribed dosing for both oral Risperdal® and Risperdal® CONSTA™. The prescription information section below may be completed for continued Risperdal® CONSTA™ therapy extending beyond 3 weeks.**

PRESCRIPTION INFORMATION

Patient Name JOHN DOE

Dosage 2 mg Sig. 1 BID Quantity 4 months

Number of Refills _____

State License # ABC1234

To the best of my knowledge, this patient does not have prescription drug insurance coverage (including Medicaid, county funded, or other public programs) for Risperdal®. Janssen Pharmaceutica Products, L.P. 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 SSSSSSSSSSS Date 1-23-4567

JAN 2004

JANSSEN CARES

PO BOX 222098
CHARLOTTE, NC 28222-2098

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 RISPERDAL®(risperidone) to Lash Group. Lash Group runs the RISPERDAL® Patient Assistance Program (the "Programs") for Janssen Pharmaceutica Products, L.P. the maker of RISPERDAL®.

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 Janssen will use and give out this information to see if I qualify for the Programs and to run the Programs. People who work for and with Lash Group and Janssen may also see my information, but they may use it only to help me get assistance with the costs of my drugs. 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 Programs. 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 Janssen, 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 Janssen.

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 Programs.

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.