

Janssen CarePath cannot accept any information without an executed Business Associate Agreement or Patient Authorization Form, which can be found at JanssenCarePath.com or as the last page of this document.

1. PATIENT INFORMATION (REQUIRED)

NAME (First, MI, Last) _____
 DOB (MM/DD/YYYY) _____ ZIP CODE _____
 CELL PHONE _____ ALTERNATE PHONE _____
 PREFERRED NUMBER TO CALL CELL ALTERNATE BEST TIME TO CONTACT MORNING AFTERNOON EVENING

2. INSURANCE INFORMATION (REQUIRED. Please fill out this section in its entirety.)

PRIMARY MEDICAL INSURANCE _____ PHARMACY BENEFIT OR SECONDARY INSURANCE _____
 CARDHOLDER _____ CARDHOLDER _____
 PHONE _____ PHONE _____
 GROUP # _____ POLICY # _____ GROUP # _____ POLICY # _____

3. PRIOR THERAPIES

Corticosteroids Cosentyx® Cyclosporine Enbrel® Humira® Methotrexate Otezla® Phototherapy Soriatane® Stelara® Taltz®
 Other _____ None

4. PRESCRIPTION INFORMATION (If requesting benefits investigation only, do not complete this section. The prescription is only valid if received by fax. If not faxed, prescription must be submitted on state-specific blank, if applicable for your state.)

Rx **TREMFYA®** **DIAGNOSIS: PSORIASIS L40.00** (Psoriatic vulgaris / Plaque psoriasis)
DIRECTIONS 1 single-dose prefilled syringe; 100 mg at Week 0, Week 4, and every 8 weeks thereafter Refills # _____
PRESCRIBER SIGNATURE (NO STAMPS ALLOWED) REQUIRED TO VALIDATE PRESCRIPTION: I certify that therapy with TREMFYA® is medically necessary for this patient. I will be supervising the patient's treatment accordingly, and I have reviewed the current TREMFYA® full Prescribing Information. I authorize Janssen CarePath to act on my behalf for the limited purposes of transmitting this prescription to the appropriate pharmacy designated by me, the patient, or the patient's plan.
PRESCRIBER SIGNATURE (Dispense as written) _____ DATE _____
SUPERVISING PHYSICIAN SIGNATURE (if applicable) _____ DATE _____
 SUPERVISING PHYSICIAN NAME _____

5. PsO Simple Trial Program

Rx **TREMFYA®** **DIRECTIONS:** **Starter Dose:** 1 single-dose prefilled syringe, 100 mg at Week 0
 SHIP FIRST DOSE TO PHYSICIAN OFFICE: Yes No
 ADDRESS _____
 CITY _____ STATE _____ ZIP CODE _____
PRESCRIBER SIGNATURE (NO STAMPS ALLOWED) REQUIRED TO VALIDATE PRESCRIPTION: I certify that therapy with TREMFYA® is medically necessary for this patient. I will be supervising the patient's treatment accordingly, and I have reviewed the current TREMFYA® full Prescribing Information. I authorize Janssen CarePath to act on my behalf for the limited purposes of transmitting this prescription to Wegmans Pharmacy. I also indicate that I would like to enroll the patient in the PsO Simple Trial Program. I understand that the patient will be contacted by Wegmans Pharmacy, on behalf of Janssen CarePath, to initiate therapy and schedule shipping of his/her medication.
PRESCRIBER SIGNATURE (Dispense as written) _____ DATE _____
SUPERVISING PHYSICIAN SIGNATURE (if applicable) _____ DATE _____
 SUPERVISING PHYSICIAN NAME _____

6. PRESCRIBER INFORMATION (REQUIRED)

PRESCRIBER NAME (First, Last) _____ OFFICE CONTACT NAME _____
 SITE NAME _____
 ADDRESS _____
 CITY _____ STATE _____ ZIP CODE _____
 PHONE _____ FAX _____ TAX ID # _____ NPI # _____

7. PRIOR AUTHORIZATION (Automatically provided with benefits investigation. You may opt out by checking the box below.)

PRIOR AUTHORIZATION FORM ASSISTANCE AND STATUS MONITORING: Janssen CarePath assists your office in providing the requirements of the patient's health plan related to prior authorization for treatment with TREMFYA®. Assistance includes obtaining the health plan-specific prior authorization form, and providing it to your office for completion and submission in the office's sole discretion. Janssen CarePath also actively monitors the status of prior authorization submission to the patient's plan and provides status updates to your office with respect to this patient's prior authorization for treatment with TREMFYA®.
 I do **NOT** wish to receive Prior Authorization Form Assistance or Status Monitoring.

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Please see full [Prescribing Information](#) and [Medication Guide](#) for TREMFYA®. Provide the Medication Guide to your patients and encourage discussion.