J&J withMe

Need help?

Call **844-494-8463**
Monday–Friday, 8:00 AM–8:00 PM ET
Multilingual phone support available
Fax: **855-998-4422**

inlexzo™ gemcitabine intravesical system | 225 mg

Patient Enrollment Form

Access and affordability resources plus personalized support for your patients

J&J withMe is your single source for access, affordability, and treatment support programs from Johnson & Johnson.

- Access support—to help navigate payer processes
- Affordability resources—to help patients discover ways to afford INLEXZO™
- Dedicated, free 1-on-1 support for your patients throughout their treatment journey—each patient's INLEXZO™ treatment journey is unique. We're here to help by providing personalized 1-on-1 support from oncology-trained nurses*

By completing and submitting a Patient Enrollment Form (PEF), both patient and healthcare provider agree to have patient screened for and, if eligible, offered enrollment in the following support offerings:

J&J withMe Savings Program: Your eligible patients pay $5 per treatment for INLEXZO™ out-of-pocket treatment costs and $0 per treatment for certain treatment administration costs. Maximum program benefit per calendar year shall apply. Offer subject to change or end without notice. Patients may participate without sharing their income information. See program requirements at **Inlexzo.JNJwithMeSavings.com**.

J&J withMe Care Navigator Outreach: J&J withMe offers a dedicated Care Navigator at no cost to eligible patients over 18 with a prescription for approved on-label use. After submitting this form, your patient can expect to receive a phone call from a J&J withMe Case Manager within 1–2 business days. The Case Manager will describe the program, including Care Navigator support, to your patient and complete the enrollment process.

Johnson & Johnson Patient Assistance Program
Additional Affordability Support

Patient assistance is available if your patient is uninsured or has commercial, employer-sponsored, or government coverage that does not fully meet their needs. Your patient may be eligible to receive their medicine from J&J at no cost for up to one year if they meet the eligibility and income requirements for the Johnson & Johnson Patient Assistance Program. See terms and conditions at **PatientAssistanceInfo.com** or call 833-742-0791.

*Care Navigators do not provide medical advice.

Instructions to complete the Patient Enrollment Form

For prescribers

- ✓ Complete the required Prescriber Information and Prescription Information sections on page 3
- ✓ Complete the required Treatment Location section on page 4
- ✓ If prior authorization assistance is NOT needed, check the appropriate box in the Prior Authorization section on page 4 to opt out

For patients/care partners

- ✓ With your patient, complete the Patient Information, Patient Consents, and Insurance Information sections on pages 3 and 4, respectively
- ✓ Please have your patient sign the Patient Authorization Form and submit with this completed Patient Enrollment Form
  - Give your patient a copy of the signed Patient Authorization Form and submit the original via fax or upload to the Provider Portal

Fax the completed and signed Patient Enrollment Form to J&J withMe at 855-998-4422.

Here's what happens next

For prescribers

J&J withMe will:

- ✓ Provide you with a verification of benefits
- ✓ Provide prior authorization assistance (as applicable)

For patients/care partners

J&J withMe will:

- ✓ Call your patients by phone to review benefits and offer enrollment into access and affordability programs the patient is eligible for
- ✓ If the patient qualifies for the Johnson & Johnson Patient Assistance Program, the pharmacy might also call them to arrange their shipment. Their caller ID will say "Healthcare"

Please read full Prescribing Information for INLEXZO™.

Patient Consents and Certifications

Enrolling in J&J withMe. I am enrolling in J&J withMe (the "Program"), and I authorize Johnson & Johnson Health Care Systems Inc., its affiliated companies, including Patient Service Center LLC, and its vendors, agents, and representatives (collectively, "Johnson & Johnson") to provide me support under the Program. Such support may include:

(i) Access and Affordability Support: The Program will help explain insurance coverage, cost support options, and support offerings like the J&J withMe Savings Program.

(ii) Prior Authorization Assistance: The Program will help support the prior authorization and appeals process.

(iii) Care Navigator Outreach: The Program provides eligible patients with a Care Navigator for support at no cost.

Verification of Eligibility. If applicable, I authorize Johnson & Johnson to verify my eligibility for the Program, and I understand that such verification may include contacting me or my healthcare provider for additional information and/or reviewing additional insurance, medical information, and/or financial information. I understand that eligibility for participation in support offerings will be verified periodically.

Conditions of Participation. If I participate in the J&J withMe Savings Program, I certify that I will not submit any costs paid by the Program as a claim for payment to any health plan, foundation, flexible spending account, or healthcare savings account. I agree to notify the Program if my insurance changes. Additionally, I understand that the Program may be changed or discontinued without notice.

Use of Personal Information. I understand that my personal health data, contact information, and other identifying information shared by me, my healthcare provider, or others with Johnson & Johnson is collected to administer the Program and for other Johnson & Johnson business purposes, as explained in Johnson & Johnson's **Privacy Policy** and, if applicable, its affiliated, noncommercial dispensing pharmacy, Access Therapy Center ("Pharmacy"), in accordance with its **Notice of Privacy Practices**.

I understand my consent is needed for processing sensitive personal data under certain privacy laws, and I can withdraw my consent anytime by completing the Privacy Request Form found in the Privacy Policy.

Depending on where I live, I may have rights regarding my information privacy, including requesting access to or deletion of my personal information. California residents have specific privacy rights detailed in Johnson & Johnson's California privacy notice.

I understand Johnson & Johnson might not be required to fulfill my requests in certain situations. To exercise these rights, I can contact Johnson & Johnson at 800-526-7736 or complete the Privacy Request Form in the Privacy Policy.

Communications. I authorize Johnson & Johnson to communicate with me by mail, email, telephone (including cell phone) and, if I indicate my agreement and consent in Section 2, by text message (automated and recurring) at the address, email address, phone number, and mobile telephone number(s) provided in Section 1. I agree to notify Johnson & Johnson promptly if any of my contact information changes in the future. I understand and acknowledge that communications via mail, email, and telephone may include information about the Program, including Rx notifications and if I indicate my agreement and consent in Section 1, information about INLEXZO™, disease state and products, promotions, services, research studies, educational and adherence materials, and to seek my opinion about such information and topics, including market research and disease-related surveys. I understand and acknowledge that communications via text message may include information about the Program, including refill reminders and Rx notifications. I understand that I may opt out of receiving future communications at any time by notifying Johnson & Johnson or by following the instructions provided. I understand that if I opt in to receive text messages, the frequency of these messages may vary. I understand that I may opt out of receiving future text messages at any time by replying "STOP," and that I can get help for text messages at any time by replying "HELP" for assistance. Message and data rates may apply. For text message terms and conditions, please **click here**. I understand and acknowledge that my personal information, including my health information, may be used or disclosed as part of the communications, including in any voicemails. Communications transmitted via unencrypted email or text message over an open network may be inherently unsecured, and there is no assurance of confidentiality for information communicated in this manner. Further, emails and text messages have inherent privacy risks, especially when access to computers or mobile devices is not password protected. Nevertheless, I want Johnson & Johnson to communicate with me via email and/or text message as detailed herein. Lastly, I understand that my consent to receive the communications is not required as a condition of participating in the Program, purchasing any goods or services, or receiving any other selected communications from Johnson & Johnson.

Terms and Conditions. Please see links to full program terms and conditions on page 1.

If you have questions, want to update your information, or terminate your enrollment, please call 844-4withMe (844-494-8463), Monday–Friday, 8:00 AM–8:00 PM ET or write to us at P.O. Box 15510, Pittsburgh, PA 15244.

Prescriber Certifications

By submitting the Patient Enrollment Form, I certify that: The person named on the form is my patient; the information provided therein is, to the best of my knowledge current, complete, and accurate; INLEXZO™ is medically necessary for this patient; I have prescribed INLEXZO™ to the patient; the decision to prescribe INLEXZO™ was based solely on my independent medical judgment; and I am authorized under state law to prescribe INLEXZO™, have reviewed and signed the prescription, and have otherwise lawfully complied with prescribing requirements under applicable laws and regulations. I will be supervising the patient's treatment, and I have reviewed the current Prescribing Information for INLEXZO™. Further, I certify that I have reviewed this form with my patient, and that the patient would like to be screened for eligibility for J&J withMe (the "Program") support offerings and provided, if applicable, the following support as described above: (i) Access and Affordability Support, through which the Program will investigate and provide information on insurance coverage, affordability, and other support options; (ii) J&J withMe Savings Program; (iii) Prior Authorization Assistance, through which the Program will support prior authorization required by a patient's health plan for coverage of treatment with INLEXZO™; (iv) J&J withMe Care Navigator, a dedicated navigator who reaches out to provide certain support resources at no cost to eligible patients; and (v) Johnson & Johnson Patient Assistance Program, through which eligible patients may receive INLEXZO™ at no cost for up to one year.

I understand that my patient's information provided to Johnson & Johnson is for the use of the Program solely to verify my patient's insurance coverage; to facilitate the filling of my patient's prescription; to assess my patient's eligibility for the Program offerings and other support programs; and to otherwise administer the Program for the patient. I certify that I am disclosing the patient's protected health information ("PHI") on this form to the Program for treatment, payment, or healthcare operations purposes, in accordance with the requirements under the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, as amended ("HIPAA"). Additionally, I certify that I have obtained the patient's written consent or authorization in accordance with applicable state and federal law, including HIPAA, to provide the PHI on this form to the Program for the purposes set forth here.

I authorize the Program to conduct a benefits investigation for my patient and to act on my behalf for the limited purpose of transmitting this prescription to the appropriate pharmacy based on the results of that benefits investigation. If coverage is available, the Program is authorized to transmit this prescription to a commercial pharmacy based on the patient's health plan requirements unless patient expresses a preference for a different pharmacy. If coverage is not available and the patient qualifies for and enrolls in the Johnson & Johnson Patient Assistance Program to receive product at no cost, the Program is authorized to transmit this prescription to a pharmacy that dispenses product at no cost under those programs. I also understand that no request for reimbursement for product at no cost may be submitted to any payer, including Medicare and Medicaid, and that no product at no cost may be sold, traded, or distributed for sale. I consent to Johnson & Johnson contacting me by fax, mail, or email to provide additional information about INLEXZO™ or the Program. I understand that the Program may revise, change, or terminate any program offerings or resources at any time without notice to me.

Please read full Prescribing Information for INLEXZO™.

J&J withMe

UPDATE 09.25

Patient Enrollment Form

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Complete and fax this form to 855-998-4422. All fields are required unless marked optional. For assistance, prescribers can call 833-JNJ-wMe1 (833-565-9631), Monday–Friday, 8:00 AM–8:00 PM ET. A completed Patient Authorization Form, found on page 5 of this document, is necessary to access certain patient support under J&J withMe. Please have your patient sign the Patient Authorization Form and submit with this completed Patient Enrollment Form.

1. Patient Information—to be completed by Patient and Provider (Required)

First Name _____ MI _____ Last Name _____

☐ Male ☐ Female Date of Birth (MM/DD/YYYY) _____ Preferred Language ☐ English ☐ Spanish ☐ Other

Address _____ City _____ State _____ ZIP _____

Patient Email _____

Phone (one required): Home _____ Mobile _____

Best Time to Contact (optional) _____ ☐ AM ☐ PM

Care Partner First Name _____ Care Partner Last Name _____
(A care partner/contact is someone who can be contacted in place of the patient)

Care Partner/Contact Phone _____

☐ If I cannot be reached, I authorize J&J withMe to contact my care partner. ☐ I prefer and authorize J&J withMe to contact my care partner in place of me.

Please sign the Patient Authorization on page 5.

2. Patient Consents—to be completed by Patient and Provider

CONSENT TO PROCESS MY SENSITIVE PERSONAL INFORMATION: Through my submission of this J&J withMe Patient Enrollment Form, I consent to the collection, use, and disclosure of my sensitive personal information, including health data, for the purposes described in this form and as described in Johnson & Johnson's **Privacy Policy**. My consent is required to process sensitive personal information under certain privacy laws, and I have the right to withdraw my consent at any time by visiting "Privacy Request Form," accessible via the Privacy Policy.

☐ **TEXT MESSAGE CONSENT (OPTIONAL):** I consent to receive automated and recurring messages from Johnson & Johnson as set forth on page 2 to the mobile number provided above. Message and data rates may apply. Message frequency varies. I understand that I am not required to consent as a condition of participating in J&J withMe, purchasing any goods or services, or receiving any other communications I have selected. I can reply HELP for help. I can reply STOP to opt out at any time.

☐ **MARKETING CONSENT (OPTIONAL):** I consent to receive communications from Johnson & Johnson and its agents (including service providers on its behalf) regarding its products, programs, services, scientific research and other research opportunities, and for online targeted advertising, as further described in Johnson & Johnson's **Privacy Policy**.

Please see Patient Consents and Certifications on page 2 for full details.

3. Prescriber Information—to be completed by Physician (Required)

First Name _____ Last Name _____ Specialty _____

Practice Name _____ Office Contact Name _____

Address _____ City _____ State _____ ZIP _____

Email _____ Office Contact Phone _____ Fax _____

Medicaid/Medicare Provider # _____ Tax ID # _____

State License # _____ NPI _____

4. Prescription Information—to be completed by Physician (Required)

ICD-10 Diagnosis Code(s): _____

☐ 1 sterile unit dose of INLEXZO™ q3 weeks
Cartons # (for 1 administration) 1 Refills 7

☐ 1 sterile unit dose of INLEXZO™ q12 weeks
Cartons # (for 1 administration) 1 Refills 5

PRESCRIBER SIGNATURE(S) (NO STAMPS ALLOWED) REQUIRED TO VALIDATE PRESCRIPTION: I certify that therapy with INLEXZO™ is medically necessary for this patient. I will be supervising the patient's treatment accordingly, and I have reviewed the current full Prescribing Information for INLEXZO™. By signing below, I authorize the Pharmacy, its affiliates, agents, and contractors to act on my behalf for the limited purposes of transmitting this prescription, by any means allowed under applicable law, to the appropriate pharmacy.

INLEXZO™ Support Program Prescription

By submitting this prescription, I understand the Program will check the patient's eligibility for and may enroll the patient in certain support programs including Johnson & Johnson Patient Assistance Program based on the results of the benefits investigation with patient consent. If the patient is eligible for support programs, I certify that I agree to the programs' requirements and will take the necessary actions described in the requirements for the patient. See program requirements on page 2.

Prescriber Signature (Dispense as written) _____ DATE _____

Triage prescription to Accredo Pharmacy (Optional): Sign below to triage to Accredo Pharmacy. Do NOT sign if you will acquire the product through buy and bill or your self-dispensing pharmacy.

Prescriber Signature (Dispense as written) _____ DATE _____

Please read full Prescribing Information for INLEXZO™.

J&J withMe UPDATE 09.25

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5. Treatment Location—to be completed by Physician (Required)

Treatment Location Type

☐ Prescribing MD's Office ☐ ASC (Ambulatory Surgical Center) ☐ Hospital Outpatient ☐ Hospital Inpatient ☐ Other _____

Provider Information

If prescribing MD's office, the fields below do not need to be completed if information is the same as the Prescriber Information section.

Provider First Name _____ Provider Last Name _____ Physician Specialty _____

Practice Name _____

Address _____

City _____ State _____ ZIP _____

Site Phone _____ Site Fax _____

PTAN (Medicare patients only) _____ Site Tax ID # _____

6. Insurance Information (Complete for all available insurance and submit copies of front and back of all insurance cards)

Fields marked with an (*) are required

Primary Medical Insurance _____ Phone _____

Cardholder Name (First, MI, Last) _____ Relationship to Cardholder _____

Member ID or Policy # _____ Group # _____ Fax _____

Secondary Medical Insurance _____ Phone _____

Cardholder Name (First, MI, Last) _____ Relationship to Cardholder _____

Member ID or Policy # _____ Group # _____ Fax _____

*Cardholder Employer Name _____ *Cardholder Employer Phone _____

*Address Line 1 _____ Address Line 2 _____

*City _____ *State _____ *ZIP _____

☐ **Please investigate out-of-network benefits.**

7. Prior Authorization—to be completed by Physician (Optional)

Automatically provided with benefits investigation. You may opt out by checking the box below.

Prior Authorization Form Assistance and Status Monitoring: J&J withMe assists your office in providing the requirements of the patient's health plan related to prior authorization for treatment with the medicine specified on this form. Assistance includes obtaining the health plan-specific prior authorization form and providing it based upon the patient-specific information provided on this form. The partially completed prior authorization form, if received from the health plan, will be provided to your office for possible completion and submission in the office's sole discretion. J&J withMe 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 the medicine specified on this form.

☐ I do **NOT** wish to receive Prior Authorization Form Assistance or Status Monitoring.

The patient support and resources provided by J&J withMe are not intended to give medical advice, replace a treatment plan from the patient's healthcare provider, offer services that would normally be performed by the provider's office, or serve as a reason to prescribe INLEXZO™.

Information about your patients' insurance coverage, cost support options, and treatment support is given by service providers for J&J withMe. The information you get does not require you or your patients to use any J&J product. Because the information we give you comes from outside sources, J&J withMe cannot promise the information will be complete.

Please read full Prescribing Information for INLEXZO™.

PATIENT AUTHORIZATION FORM ("AUTHORIZATION")

By signing below, I give permission for each of my "Healthcare Providers" (eg, my physicians, pharmacists, specialty pharmacies, other healthcare providers, and their staff) and "Insurers" (eg, my health insurance plans) to share my Protected Health Information ("PHI") as described under J&J's support programs. My PHI includes any and all information related to my medical condition, treatment, prescriptions, health insurance coverage, and other information contained in the Patient Enrollment Form.

I agree that the following entities are permitted to receive, use, and share my PHI:

- Johnson & Johnson Health Care Systems Inc., its affiliated companies, including Patient Service Center LLC, agents, and representatives (collectively "J&J"); and
- Providers of other sources of funding (including foundations and co-pay assistance providers), service providers for J&J's support programs (including subcontractors or healthcare providers helping J&J run the program), and service providers maintaining, transmitting, de-identifying, aggregating, or analyzing data from J&J's support programs (collectively, "Service Providers");
- Pharmacies involved in my care; and Insurers

Also, I give permission to J&J, the Service Providers, my Healthcare Providers, and my Insurers to receive, use, and share my PHI in order to:

- see if I qualify for, sign me up for, contact me about, and provide services relating to J&J's patient support programs, including in-home services
- communicate with my Healthcare Providers regarding access to, reimbursement for, and fulfillment of my J&J medicine, and to tell my Healthcare Provider that I am participating in a support program from J&J
- verify, assist with, and coordinate my coverage for my J&J medicine with my Insurers and Healthcare Providers
- coordinate prescription or treatment location and associated scheduling
- conduct analysis to help J&J evaluate, create, and improve its products, services, and customer support for patients prescribed J&J medicines
- share and give access to information created by J&J's patient support programs that may be useful for my care
- communicate with me by telephone, text message, or email regarding J&J's support programs or other J&J medicines, products, or services for the purposes set forth in the Patient Enrollment Form

I understand that J&J and the Service Providers will use reasonable efforts to keep my information private but once my PHI is disclosed as allowed on this Authorization, it may no longer be protected by federal privacy laws. I understand that I am not required to sign this Authorization. My choice about whether to sign will not change how my Healthcare Providers or Insurers treat me. If I do not sign this Authorization, or cancel or remove my permission later, I understand I will not be able to participate in or receive assistance from certain J&J support programs. I understand that pharmacies that dispense and ship my medicine and service providers for J&J's support programs may be paid by J&J for their services and data. This may include payment for sharing PHI and other data in connection with this program, as allowed on this Authorization.

I understand I may request a copy of this Authorization. This Authorization will remain in effect 10 years from the date of signature, except where state law requires a shorter time, or until I am no longer participating in J&J's support programs. Information collected before that date may continue to be used for the purposes set forth in this Authorization. I understand that I may cancel the permissions given by this Authorization at any time by letting J&J know in writing at: Johnson & Johnson, PO Box 15510, Pittsburgh, PA 15244. I can also cancel my permission by letting my Healthcare Providers and Insurers know in writing that I do not want them to share any information with J&J. I further understand that if I cancel my permission it will not affect how J&J uses and shares my PHI received by J&J prior to my cancellation.

My signature below certifies that I have read, understood, and agreed to the release of my protected health information pursuant to this Authorization.

REQUIRED – SIGNATURE OF PATIENT OR PATIENT'S LEGALLY AUTHORIZED REPRESENTATIVE*:

_____ Date: _____ /_____ /_____

Print Patient Name: _____ Email Address: _____

Print Legally Authorized Representative Name (if applicable): _____

Relationship to Patient (if applicable): _____

*Only individuals with legal authority to make medical decisions for the patient may sign.