Palmetto INFUSION®

Phone: 1-800-809-1265 Fax: 1-866-872-8920

AMBULATORY INFUSION AND IN HOME ORDERS/SPECIALTY ORDERS			
Referral Status:		MRN:	
☐ New referral	☐ Order change	☐ Order Renewal	
Patient preferred clinic:			

Tremfya® (guselkumab) Standard Plan of Treatment for Gastroenterology

Rev 4.28.25

PATIENT DEMOGRAPHICS:

Patient Name:					
Patient's Phone:		Address:			
Date of Birth:		City, State, Zip:			
Height in inches:	Weight: LB or KG	Gender:	Allergies:	☐ See list	☐ NKDA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

☐	K51.0_____ - Ulcerative (Chronic) pancolitis	☐	K51.5_____ - Left sided colitis
☐	K51.2_____ - Ulcerative (Chronic) Proctitis	☐	K51.8_____ - Other ulcerative colitis or Unspecified
☐	K51.3_____ - Ulcerative (Chronic) Rectosigmoiditis	☐	K51.9_____ - Ulcerative colitis, unspecified
☐	K50.9_____ - Crohn's disease, unspecified	☐	_____Other: _____
☐	K51.0_____ - Ulcerative (chronic) pancolitis	☐	

REQUESTED DOCUMENTATION:

1	Insurance information
2	Most recent History & Physical
3	Full medication list
4	Tried and failed therapies
5	**REQUIRED:** TB screening for new start patients

PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

IF NO: PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:

IF YES:
LAST INFUSION DATE:
NEXT INFUSION DATE:

IF ORDER CHANGE:

☐ **Continue current order until insurance approved**

AMBULATORY INFUSION MEDICATION ORDERS:

NOTE: Patient may be ineligible to receive guselkumab if receiving antibiotics for active infectious process, antifungal therapy, active fever and/or suspected infection, new-onset or deterioration neurological changes, and/or surgery

PREMEDICATION TO BE ADMINISTERED 30 MINUTES PRIOR TO ADMINISTRATION AS SELECTED

IV

Diphenhydramine	☐	25mg	☐	50mg			
Methylprednisolone	☐	40mg	☐	125mg	☐	Other:	
Famotidine	☐	20mg	☐	40 mg			
Other:	☐						

PO

Acetaminophen	☐	325mg	☐	500mg	☐	650mg	☐	1000mg
Famotidine	☐	20mg	☐	40mg				
Diphenhydramine	☐	25mg	☐	50mg				
Fexofenadine	☐	60mg	☐	180mg				
Cetirizine	☐	10mg						
Loratadine	☐	10mg						
Other:	☐							

MEDICATION/DOSE/FREQUENCY:

☐ Induction: Tremfya® (guselkumab) 200mg administered by IV in 250ml NS over at least 1 hour at week 0, week 4, and week 8.

SPECIAL/OTHER LAB ORDERS:

☐ _____

IN HOME/SPECIALTY PHARMACY ORDERS:

☐ Maintenance: Tremfya® (guselkumab) 100mg subcutaneously at week 16 and every 8 weeks thereafter.

☐ Maintenance: Tremfya® (guselkumab) 200mg subcutaneously at week 12 and every 4 weeks

Some commercial insurance plans require maintenance doses to be provided by the plan's specialty pharmacy. Providers will be notified if Palmetto Infusion cannot dispense the maintenance doses due to plan restrictions or patient preference.

☐ Other: _____

☑ Refills x 12 months unless noted otherwise here:

LINE USE/CARE ORDERS:

- ☑ Start PIV/Access CVC
- ☑ Flush device per facility standard flushing procedure
- ☑ Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated
- ☑ In In Home Supply orders: All supplies for drug administration and ADR kit to be provided for in home use.

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders which can be found on the website. Home Standing orders including Anaphylaxis Kit dispense as written and administer for mild and severe reactions are provided.

PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures)

DATE:

Dispense as written/Brand medically necessary	Substitution permitted	

Tremfya withMe | Tremfya® (guselkumab)

Gastroenterology Patient Enrollment Form

UPDATE 09.24

Complete and fax this form to 800-600-7226. For assistance, prescribers can call 844-4withMe (844-494-8463), Monday–Friday, 8:00 AM–8:00 PM ET. A completed Patient Authorization Form, found on pages 3 and 4 of this document, is necessary to access certain patient support under TREMFYA withMe. Please have your patient sign the Patient Authorization Form and submit with this completed Patient Enrollment Form. The information you provide will be processed by Janssen Biotech, Inc., and its service providers in accordance with its Privacy Policy and, if applicable, its affiliated pharmacy, in accordance with HIPAA.

Comprehensive support to help your patients start and stay on prescribed treatment

We will help verify insurance coverage, support and monitor the prior authorization process, provide reimbursement information, help find affordability options for eligible patients, and provide ongoing support to help patients start and stay on TREMFYA®. Patient support available for eligible patients prescribed TREMFYA®:

TREMFYA withMe Savings Program: Eligible patients using commercial or private insurance can save on out-of-pocket costs for TREMFYA®. Eligible patients may pay $0 per dose. See program requirements at TREMFYAwithMeSavings.com. After submitting this form, patient can expect to receive a call from their Case Manager for enrollment if eligible.

TREMFYA withMe Access Program: For eligible patients who experience a delay of >5 business days or a denial of coverage, TREMFYA withMe offers TREMFYA® at no cost for up to 3 years or until their commercial insurance covers the medication. See program requirements at TremfyawithMeAccess.com. To have your patient enrolled in the TREMFYA withMe Access Program if they are eligible, a TREMFYA® prescription must be completed in section 5.

TREMFYA withMe Nurse Guide* Outreach: TREMFYA withMe offers a dedicated Nurse Guide at no cost to patients **age 18 and older who have been prescribed TREMFYA®** for on-label use. After submitting this form, your patient can expect to receive a phone call from their TREMFYA withMe Nurse Guide within 1–2 business days. The Nurse Guide will describe the program to your patient and complete the enrollment process. A TREMFYA withMe Nurse Guide cannot reach out to your patient without an executed Patient Authorization Form, which can be found on pages 3 and 4 of this document. *Nurse Guides do not provide medical advice.

Janssen Patient Assistance Program: Patient assistance is available if your patient has commercial, employer-sponsored, or government coverage that does not fully meet their needs. Your patient may be eligible to receive their Janssen medication free of charge for up to one year if they meet the eligibility and income requirements for the Janssen Patient Assistance Program. To have your patient enrolled in the Janssen Patient Assistance Program if they are eligible, a TREMFYA® prescription is required in section 5.

▼ TO BE COMPLETED BY PATIENT AND PROVIDER ▼

1. Patient Information (REQUIRED)

NAME (First, M, Last) _____ DOB (MM/DD/YYYY) _____ SEX ☐ M ☐ F

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

PHONE _____ EMAIL ADDRESS _____

☐ **The patient has consented to treatment by the Pharmacy and has authorized the collection, use, and disclosure of their health information as described in the Privacy Policy. I understand that the Pharmacy may be contacting the patient by phone or otherwise concerning this program.**

2. Insurance Information (REQUIRED. Complete fields below OR provide a copy of the front and back of insurance cards.)

Medical Insurance _____ POLICY# _____ GROUP# _____

CARDHOLDER _____

Pharmacy Insurance _____ PCN# _____ GROUP# _____

CARDHOLDER _____ CARD/BIN# _____

▼ TO BE COMPLETED BY PROVIDER ▼

3. Clinical Information (REQUIRED)

TREMFYA®—DIAGNOSIS

DATE OF DIAGNOSIS OR YEARS WITH DISEASE _____ PREVIOUS TB TEST (DATE) _____

Select One: ☐ K51.9 Ulcerative Colitis, Unspecified ☐ Other ICD-10 Code _____

Date of first infusion

Start date: _____ ☐ Not yet started If not yet started, estimated start date: _____

PRIOR MEDICATIONS

☐ 5-ASA ☐ 6-MP ☐ Azathioprine ☐ Corticosteroids ☐ Cyclosporine ☐ Entyvio® ☐ Humira® ☐ Omvoh™ ☐ Rinvoq® ☐ Skyrizi® ☐ Velsipity™ ☐ Xeljanz® ☐ Zeposia® ☐ Zymfentra™ ☐ None ☐ Other _____

4. Prescriber Information (REQUIRED)

PRESCRIBER NAME (First, Last) _____ OFFICE CONTACT _____

PRACTICE NAME _____ NPI# _____ TAX ID# _____

ADDRESS _____ CITY _____

STATE _____ ZIP CODE _____ PHONE _____ FAX _____

5. Prescription Information (Required to complete benefits investigation.)

Rx TREMFYA® INDUCTION THERAPY

(If patient qualifies for and enrolls in the TREMFYA withMe Access Program or Janssen Patient Assistance Program, this prescription will be used by the Access Therapy Center [non-commercial pharmacy] to dispense the patient's TREMFYA®.)

☐ 200 mg at week 0, week 4, and week 8 Vials # (for 1 infusion) ___1___ Refills: ___2___

SHIP TO INDUCTION/SITE OF INFUSION:
(NOTE: REQUIRED IF DIFFERENT FROM PRESCRIBER'S OFFICE. Shipments cannot be sent to PO boxes.)

☐ Nonprescriber's Office ☐ Hospital Outpatient ☐ Infusion Center ☐ Other

PHYSICIAN OR INFUSION PROVIDER NAME _____

PRACTICE/FACILITY NAME _____ NPI # _____ TAX ID# _____

ADDRESS _____ CITY _____

STATE _____ ZIP CODE _____ PHONE _____ FAX _____

Rx TREMFYA® MAINTENANCE THERAPY

☐ Single-dose prefilled pen; 200 mg/2 mL SC every 4 weeks Refills #_____

☐ Single-dose prefilled syringe; 200 mg/2 mL SC every 4 weeks Refills #_____

☐ Single-dose One-Press patient-controlled injector; 100 mg/mL SC every 8 weeks Refills #_____

☐ Single-dose prefilled syringe; 100 mg/mL SC every 8 weeks Refills #_____

TREMFYA® Support Program Prescription

Signature required to enroll eligible patients in the TREMFYA withMe Access Program or Janssen Patient Assistance Program.

PRESCRIBER SIGNATURE (Dispense as written) _____ DATE _____

By submitting this prescription, I understand the Pharmacy will check the patient's eligibility for and may enroll the patient in certain support programs 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 program's requirements and will take the necessary actions described in the requirements for the patient. See program requirements on page 2.

Commercial Pharmacy Prescription (OPTIONAL)

Patient- or provider-preferred pharmacy _____

PRESCRIBER SIGNATURE (Dispense as written) _____ DATE _____

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® Prescribing Information.

Please see the full Prescribing Information and Medication Guide for TREMFYA®.

Clear Form Print Form

Information about your patient's insurance coverage, cost support options, and treatment support is given by service providers for TREMFYA withMe via Janssen CarePath. The information you get does not require you or your patient to use any Janssen product. Because the information we give you comes from outside sources, TREMFYA withMe cannot promise the information will be complete. TREMFYA withMe cost support is not for patients in the Johnson & Johnson Patient Assistance Foundation.

TREMFYA withMe Access Program

Offers eligible patients intravenous induction & subcutaneous TREMFYA® (guselkumab) at no cost for up to 3 years or until their commercial insurance covers the medication. See program requirements below.

To be eligible, the patient must be age 18 or older and must have:

1. a TREMFYA® prescription for an FDA-approved use to treat ulcerative colitis
2. active commercial insurance with biologics coverage
3. a response from the commercial payer that TREMFYA® is not covered for ulcerative colitis when investigating the patient's insurance benefits **OR** experienced a delay of more than 5 business days or a denial of coverage from the patient's insurance carrier once a prior authorization has been submitted to commercial payer

In addition, for the patient to be eligible, the Prescriber must submit a Patient Enrollment Form along with a TREMFYA® prescription to TREMFYA withMe to receive a coverage determination from the patient's insurance.

The Prescriber must also submit a letter of medical necessity or appeal to the patient's pharmacy insurance within 90 days of the prior authorization denial of subcutaneous TREMFYA® coverage to remain eligible for the program.

The patient is not eligible if:

1. patient uses any state or federal government-funded healthcare program to cover medicine costs. Examples of these programs are Medicare, Medicaid, TRICARE, Department of Defense, and Veterans Administration
2. coverage is denied due to missing information on prior authorization or coverage determination form
3. patient is approved for commercial coverage of TREMFYA®
4. provider has not submitted an appeal within 90 days of when the patient receives their first subcutaneous maintenance dose

The program requires a periodic check of the patient's insurance coverage status to confirm their continued eligibility. The patient remains eligible for up to 3 years or until their commercial insurance covers the medicine.

The program covers the cost of medicine only—not associated administration cost. Program is good only in the United States and its territories. Void where prohibited, taxed, or limited by law. The program may change or end at any time, including in specific states.

Other requirements

- This program is only for people age 18 or older using commercial or private health insurance for TREMFYA®. This includes plans from the Health Insurance Marketplace
- This program is not for people who use any state or federal government-funded healthcare program. Examples of these programs are Medicare, Medicaid, TRICARE, Department of Defense, and Veterans Administration
- Patients may not seek payment for the value received from this program from any health plan, patient assistance foundation, flexible spending account, or healthcare savings account
- Patients must meet the program requirements every time they use the TREMFYA withMe Access Program

The patient may end their participation in the TREMFYA withMe Access Program at any time by calling 833-WITHME1 (833-948-4631).

Janssen Patient Assistance Program

Your patient may be eligible to receive their Janssen medication(s) free of charge for up to one year if they have been prescribed a Janssen medication, have a financial hardship, and are currently enrolled in government, commercial, or employer group health insurance. Your patient must meet the eligibility and income requirements to qualify for the patient assistance program. Your patient is not eligible for free Janssen medication if their health insurance will cover the cost of their Janssen-prescribed medication if this application is denied. Some employers, insurers, and other companies force patients to apply for medically necessary medications from free product programs instead of covering such medications directly and immediately through insurance, which could lead to delays in care and discriminate against lower-income patients. These types of "Assistance Diversion Programs" are generally established by companies that profit by diverting resources away from patients in need. An Assistance Diversion Program is any insurer, employer, or third-party program that withholds coverage or payment for Patient's medically necessary drug until Patient has completed an application for free product assistance. Assistance Diversion Programs are prohibited by Janssen to make sure that help is available for patients with no safety net in place. Your patient's insurer must submit a Patient Eligibility Certification form to confirm that their drug coverage is not subject to an Assistance Diversion Program. Your patient may not seek payment for the value of Janssen medications received from this program from any health plan, patient assistance foundation, flexible spending account, or healthcare savings account. Before your patient enrolls in the patient assistance program, it is important they understand that they will be asked to provide personal information that may include their name, address, phone number, email address, financial information, and information related to their prescription medication insurance and treatment. This information will be used by Janssen Biotech, Inc., and its service providers to determine their eligibility for, enroll them in, and administer the program. The information will also be used to learn more about the people who use the program, to improve the program, and will be shared with service providers supporting the program. If your patient has Medicare Prescription Drug Coverage (Part D) they may be asked to attest to or submit a report from their pharmacy or an Explanation of Benefits (EOB) statement from their insurer that shows their out-of-pocket costs for the current year. To qualify for the program, 4% of the patient's gross annual household income must be spent on out-of-pocket prescription expenses for the patient and/or other members of their household. This program offer may not be used with any other coupon, discount, prescription savings card, free trial, or other offer. Offer good only in the United States and its territories. Void where prohibited, taxed, or limited by law. Program terms will expire at the end of each calendar year and may change or end without notice, including in specific states. Your patient may end their participation in the program at any time by calling 833-withMe1 (833-948-4631), Monday through Friday, 8:00 AM to 8:00 PM ET.

Please see the full Prescribing Information and Medication Guide for TREMFYA®.

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Janssen
PHARMACEUTICAL COMPANIES OF
Johnson & Johnson

Janssen Patient Support Program Patient Authorization Form

Patients should read the Patient Authorization, check the desired permission boxes, and return both pages of the Form to Janssen Patient Support Program.

- Download a copy, print, check the desired boxes, and sign. Your healthcare provider may scan the completed Form and upload on Provider Portal, or completed Form may be faxed to 800-600-7226 or mailed to TREMFYA withMe, PO Box 15510, Pittsburgh, PA 15244

Patient Name: _____ Email Address: _____

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 as described on this Form.
My "Protected Health Information" includes any and all information related to my medical condition, treatment, prescriptions, and health insurance coverage.
The following person(s) or class of person(s) are given permission to receive and use my Protected Health Information (collectively "Janssen"):

- Johnson & Johnson Health Care Systems Inc., its affiliated companies, agents, and representatives
- Providers of other sources of funding, including foundations and co-pay assistance providers
- Service providers for the patient support programs, including subcontractors or healthcare providers helping Janssen run the programs
- Service providers maintaining, transmitting, de-identifying, aggregating, or analyzing data from Janssen patient support programs

Also, I give permission to Janssen to receive, use, and share my Protected Health Information in order to:

- see if I qualify for, sign me up for, contact me about, and provide services relating to Janssen patient support programs, including in-home services
- manage the Janssen patient support programs
- give me educational and adherence materials, information, and resources related to my Janssen medication in connection with Janssen patient support programs
- communicate with my Healthcare Providers regarding access to, reimbursement for, and fulfillment of my Janssen medication, and to tell my Healthcare Provider that I am participating in Janssen patient support programs
- verify, assist with, and coordinate my coverage for my Janssen medication with my Insurers and Healthcare Providers
- coordinate prescription or treatment location and associated scheduling
- conduct analysis to help Janssen evaluate, create, and improve its products, services, and customer support for patients prescribed Janssen medications
- share and give access to information created by the Janssen patient support programs that may be useful for my care

I understand that my Protected Health Information may be shared by Janssen for the uses written in this Form to:

- My Insurers
- My Healthcare Providers
- Any of the persons given permission to receive and use my Protected Health Information as mentioned above
- Any individual I give permission as an additional contact

Janssen and the other data recipients listed on this Form may share information about me as permitted on this Form or if any information that specifically identifies me is removed. I understand that Janssen will use reasonable efforts to keep my information private, but once my Protected Health Information is disclosed as allowed on this Form, it may no longer be protected by federal privacy laws.

Clear Form Print Form

Janssen Patient Support Program Patient Authorization Form

I understand that I am not required to sign this Form. My choice about whether to sign will not change how my Healthcare Providers or Insurers treat me. If I do not sign this Form, or cancel or remove my permission later, I understand I will not be able to participate or receive assistance from Janssen's patient support programs.

I understand that pharmacies that dispense and ship my medication and service providers for the patient support programs may be paid by Janssen for their services and data. This may include payment for sharing Protected Health Information and other data in connection with these programs, as allowed on this Form.

This Form 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 any Janssen patient support programs. Information collected before that date may continue to be used for the purposes set forth in this Form.

I understand that I may cancel the permissions given by this Form at any time by letting Janssen know in writing at: TREMFYA withMe, 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 Janssen.

I further understand that if I cancel my permission it will not affect how Janssen uses and shares my Protected Health Information received by Janssen prior to my cancellation.

I understand I may request a copy of this Form.

Permission for communications outside of Janssen patient support programs:

☐ Yes, I would like to receive communications relating to my Janssen medication.

☐ Yes, I would like to receive communications relating to other Janssen products and services.

For privacy rights and choices specific to California residents, please see Janssen's California privacy notice available at https://www.janssen.com/us/privacy-policy#california

Permission for text communications:

☐ Yes, I would like to receive text messages. By selecting this option, I agree to receive text messages as allowed by this Form to the cell phone number provided below. Message and data rates may apply. Message frequency varies. I understand I am not required to provide my permission to receive text messages to participate in the Janssen patient support programs or to receive any other communications I have selected.

Cell phone number: _____

Patient name (print): _____

Patient sign here: _____ **Date:** _____

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

By: _____ **Print name:** _____ **Date:** _____

(Signature of person legally authorized to sign for patient)

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

_____

Clear Form Print Form

