

**Johnson & Johnson Patient Assistance Foundation, Inc.  
Hospital Access Patient Assistance Program**

Please complete each section to the fullest extent possible. If an item does not apply, please note "N/A" on that line. If you require additional space you may attach additional sheets of paper.

Please return this complete form to:

Mail: Johnson & Johnson Patient Assistance Foundation Hospital Access Patient Assistance Program  
PO Box 220455  
Charlotte, NC 28222-0455  
Telephone: (800) 652-6227  
Fax: (800) 521-2437

New Application \_\_\_\_\_

Renewal \_\_\_\_\_

**AVAILABLE PRODUCTS**

**ORAL FORMULATIONS**

Edurant® (rilivrine) Tablets  
Intelence® (etravirine) Tablets  
Invega® (paliperidone) Extended-Release Tablets  
Invokamet® (canagliflozin/metformin HCl) Tablets  
Invokana® (canagliflozin) Tablets  
Prezista® (darunavir) Tablets  
Prezcobix® (darunavir 800mg/cobicistat 150mg) Tablets  
Risperdal® (risperidone) Tablets  
Topamax® (topiramate) Tablets  
Xarelto® (rivaroxaban) Tablets

**FACILITY INFORMATION**

Name of person completing application: \_\_\_\_\_ Title: \_\_\_\_\_

Responsible site contact name: \_\_\_\_\_ Title: \_\_\_\_\_

Facility Name: \_\_\_\_\_

Street Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Tel: (\_\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_

**SHIP TO ADDRESS OF OUTPATIENT PHARMACY**

Facility Name: \_\_\_\_\_

Ship to Contact Name: \_\_\_\_\_ Title: \_\_\_\_\_

Street Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Tel: (\_\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_

Facility State License Number: \_\_\_\_\_ Facility DEA Number: \_\_\_\_\_

**ADDITIONAL FACILITY INFORMATION**

**Does your facility:**

- |   |   |
|---|---|
| <ul style="list-style-type: none"><li>• Have Disproportionate Share Hospital (DSH) Status?<br/><input type="checkbox"/> YES <input type="checkbox"/> NO</li><li>• Have an Outpatient Pharmacy where product can be stored?<br/><input type="checkbox"/> YES <input type="checkbox"/> NO</li></ul> | <ul style="list-style-type: none"><li>• Participate in the 340B Drug Pricing Program?<br/><input type="checkbox"/> YES <input type="checkbox"/> NO</li><li>• Have DRG-Exemption?<br/><input type="checkbox"/> YES <input type="checkbox"/> NO</li></ul> |
|---|---|

**APPLICANT DECLARATION**

To the best of my knowledge, the information provided is accurate and correct. Johnson & Johnson Patient Assistance Foundation, Inc. (JJPAF) 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 patients treated with product through this program.

Signature (Responsible Site Contact): \_\_\_\_\_ Date: \_\_\_\_\_