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 completed 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

Edurant® (rilivrine) Tablets
Intelence® (etravirine) Tablets
Invokamet® (canagliflozin/metformin HCl) Tablets
Invokamet® XR (canagliflozin/metformin HCl) Extended-Release Tablets
Invokana® (canagliflozin) Tablets
Prezista® (darunavir) Tablets
Prezcobix® (darunavir 800mg/cobicistat 150mg) 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:

- Have Disproportionate Share Hospital (DSH) Status?
  ☐ YES ☐ NO
- Have an Outpatient Pharmacy where product can be stored?
  ☐ YES ☐ NO
- Participate in the 340B Drug Pricing Program?
  ☐ YES ☐ NO
- Have DRG-Exemption?
  ☐ YES ☐ NO

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 eligible patients treated with product through this program.

Signature (Responsible Site Contact): _____ Date: _____