

REMICADE® (infliximab) PATIENT ASSISTANCE PROGRAM APPLICATION

Telephone (866) 489-5957 Fax (866) 489-5958

The following information is required to enable the Patient Assistance Program specialists to determine eligibility for a patient. Before eligibility is established, the application with signature must be faxed to (866) 489-5958 or mailed to the following address before product can be shipped:

REMICADE Patient Assistance Program
P.O. Box 221709
Charlotte, NC 28222-1709

New Application _____ Re-application _____
Section 1 --To be completed by patient or patient's family and submitted to physician.

Patient Information (Please Print Clearly)

_____ Male Female
 Name of Patient _____
 Name of Guardian (if appropriate) _____
 Patient's Address _____
 City _____ State _____ Zip _____
 (_____) _____ (_____) _____
 Phone Number -- Home _____ Work _____
 Date of Birth _____ SS# _____
 Family Size _____

Insurance Information

_____ Policy Number _____ Group Number _____
 Name of Insurance Co. _____
 Address _____
 City _____ State _____ Zip _____
 (_____) _____
 Phone Number _____
 Subscriber's Name _____ Date of Birth _____
 Subscriber's Relationship to Patient _____
 Secondary Insurance Name of Company Policy Number Group Number

 Address _____ City _____ State _____ Zip _____
 (_____) _____
 Phone Number _____

Financial Assessment – Required Information PLEASE COMPLETE ATTACHMENT A TO THIS APPLICATION

Net Monthly Income Patient Spouse/Other
 (Salary/Wages, Pension, Social Security
 SSI, SS Disability, Unemployment)
Total _____

Applicant Declaration

I promise that the information on this form is correct and complete. If needed, Centocor, Inc., (the Company) and the REMICADE Patient Assistance Program (the Program) may request and obtain information about my, or my family's, income to enroll me in the Program. I understand that the Program administrators reserve the right at any time and without notice to modify the application form; modify or discontinue any or all of the Program and the related eligibility criteria; or terminate assistance provided by the Program at any time.

 Patient or Guardian Signature Date

Section 2 -- To be completed by physician.

Physician Information

 Name of Physician Specialty
 Address _____
 City _____ State _____ Zip _____
 (_____) _____ (_____) _____
 Phone Number _____ Fax Number _____

Physician's State License # _____

Office Contact Name _____

Will the infusion occur in your office? Yes No If no, please indicate the infusion provider information on Attachment B.

Prescription Information

Intended
 Patient Weight _____ lbs _____ kg Dosage _____ No. Vials _____

Infusions or Infusion Dates _____

Therapy Start Date _____

Physician Services

The Centocor REMICADE Patient Assistance Program requests that, in cases of full product assistance, physicians not charge third-party payers or patients for professional services associated with the administration of REMICADE. No claim may be made to any third-party payer for payment for product or supplies 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 this patient's prescription.

 Physician's Signature Date



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ATTACHMENT A
Centocor Patient Assistance to be Completed by Patient or Guardian
Financial Documentation

Patient name: _____ Office name: _____

- (1) Are you employed? ____ Yes ____ No If yes, please list employer _____
If you did not list any insurance on the first page of this application, are you eligible to obtain insurance through your employer or your spouse's health plan? ____ Yes ____ No ____ Don't know
If yes, do you know when your next "open enrollment" period is?
____ Yes ____ No ____ Don't know If no, go to question 2.
If yes, when is the open enrollment period? _____
- (2) Do you qualify for disability benefits?
____ Yes ____ No ____ Don't know
- (3) Has patient or guardian applied to public programs such as Medicaid or state drug assistance program?
____ Yes ____ No If yes, program(s) applied to _____
- (4) Are you a veteran? ____ Yes ____ No If no, go to question 5
If yes, were you honorably discharged? ____ Yes ____ No If no, go to question 5.
If yes, are you close to a VA hospital? ____ Yes ____ No ____ Don't know
- (5) As part of the application process, the program considers income. Please attach documentation (photocopies acceptable).

Income

Gross income ____ per year ____ per month

Approx. Value

Documentation Provided

- 3 recent pay stubs, or
 Recent Workers' Compensation check stub
 Pension statement
 W-2
 Recent tax return
 None (no income source)
 Other _____

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ATTACHMENT B

Alternate Infusion Provider Information to be Completed by Requesting Physician's Office

Patient name: _____ Office name: _____

If the infusion provider is different from the requesting physician, please provide the alternate infusion provider information below. This information will be used to schedule shipment of REMICADE.

Contact name: _____

Provider name if different from contact: _____

- Provider type: Hospital outpatient
 MD office
 Home infusion
 Other _____

Street address: _____ Suite/Room # _____

City State Zip

(_____) _____
Phone number Fax number