

PATIENT AUTHORIZATION (PA) FORM FOR REMICADE® (infliximab)

Provider Instructions:

- **To be completed only when (1) there is not a valid Business Associate Contract, or (2) the Covered Entity has signed a Limitation of Services request.**
- **Patients should read the Patient Authorization and sign below.**
- **A copy of this form must be provided to the patient.**

I, _____, allow my doctor(s), any other healthcare providers, and my health plan or insurers to share information including medical records, spoken and written facts about my health or health care, payment benefits relating to my health care and my use or potential use of REMICADE® (infliximab) with Centocor Ortho Biotech Inc., its parent or affiliate, designee or successor, providers of alternate sources of funding, and other service providers supporting AccessOne® (collectively, "Centocor Ortho Biotech"). AccessOne®, the Centocor Ortho Biotech support system, will provide services related to my use or potential use of REMICADE® including, but not limited to, reimbursement support services, see if I qualify for certain support services, referring me to other programs, foundations or alternate sources of funding or coverage that may be available to provide assistance to me with the costs of my drugs, other related services, and to manage AccessOne® (collectively, "AccessOne®").

Program management employees of Centocor Ortho Biotech may also see my information, but they may use it only in connection with AccessOne®, or as otherwise required or allowed under the law. Centocor Ortho Biotech may also share my information to other parties supporting AccessOne®, if they first remove any information that identifies me. I understand that they will make every effort to keep my information private. If it is accidentally shared, federal privacy laws do not require that the person/party receiving it not disclose the information further. Information disclosed pursuant to this disclosure and provided to a third party may no longer be protected by federal privacy laws.

This Authorization will last until I am no longer participating in AccessOne®. If I change my mind, I can tell my healthcare providers and my insurers in writing that I do not want them to share any information with Centocor Ortho Biotech, but it will not change any information shared before I notified them of my desire to discontinue. My authorization will also end if AccessOne® is discontinued. I know that I have a right to see or copy the information my healthcare providers or insurers have given to Centocor Ortho Biotech.

I KNOW THAT I MAY REFUSE TO SIGN THIS FORM. My choice about whether to sign this form will not change the way my healthcare providers or insurers treat me. If I refuse to sign this form, or revoke my authorization later, I know that this means I may no longer be able to participate or receive assistance from AccessOne®.

Patient sign here: _____ Date: _____

Patient name: _____

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

Patient name: _____

By: _____

(Signature of person legally authorized to sign for patient)

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

**Fax completed form to 1-866-489-5955 or mail to
AccessOne®, P.O. Box 220829, Charlotte, NC 28222-0829**