



Prescription Information, Nursing Order and STELARA™ Support Enrollment Form

Complete and fax this form to (866) 489-5955 or mail to P.O. Box 220829, Charlotte, NC 28222-0829.

Patient Information

NAME (First, MI, Last) _____ SEX M F DOB (MM/DD/YYYY) _____
 ADDRESS _____ CITY _____
 STATE _____ ZIP CODE _____ EMAIL _____
 HOME/CELL PHONE _____ WORK PHONE _____ BEST TIME TO CONTACT _____

Insurance Information (Complete this section or provide a copy of all insurance cards)

PRIMARY INSURANCE _____ CARDHOLDER _____ RELATIONSHIP TO CARDHOLDER _____ EMPLOYER _____ INS. CO. PHONE _____ POLICY# _____ GROUP# _____ PRESCRIPTION DRUG INSURER _____ (Please include alpha prefix and suffix with policy and group# when applicable)	SECONDARY INSURANCE _____ CARDHOLDER _____ RELATIONSHIP TO CARDHOLDER _____ EMPLOYER _____ INS. CO. PHONE _____ POLICY# _____ GROUP# _____ CARD/BIN# _____ PHONE _____
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Patient Authorization (To be completed only when [1] there is not a valid Business Associate Contract with the Covered Entity, or [2] the Covered Entity has signed a Limitation of Services request. Patient should read the Patient Authorization on the Patient Copy and sign below.)

My signature below certifies that I have read, understand, and agree to the Patient Authorization to release my protected health information to Centocor Ortho Biotech Inc., its parent or affiliate, designee or successor, specialty pharmacies, providers of nursing services, and other service providers supporting AccessOne® and STELARA™ Support as defined on the Patient Copy (collectively, "Centocor Ortho Biotech"). STELARA™ Support services are part of AccessOne®.

PATIENT SIGNATURE _____ DATE _____ PATIENT NAME _____
 If patient cannot sign, patient's legally authorized representative must sign below.
 PATIENT NAME _____ BY _____
 Signature of person legally authorized to sign for patient/relationship

STELARA™ Support Extended Services Enrollment

(To be completed by a patient who wishes to enroll for Extended Services. Patient should read the Extended Services Enrollment on the Patient Copy, check the appropriate boxes, and sign below)

My signature below certifies that I agree to enroll in the STELARA™ Support Extended Services that I have checked below, and that I have read, understand, and agree to the Patient Authorization per the terms on the Patient Copy.

Of the optional extended services provided by STELARA™ Support, I would like to enroll to receive: Patient Education Materials Patient Therapy Reminders Both
 Patient must sign and check the appropriate boxes above in order to participate or receive assistance from STELARA™ Support for extended services.

PATIENT SIGNATURE _____ DATE _____ PATIENT NAME _____
 If patient cannot sign, patient's legally authorized representative must sign below.
 PATIENT NAME _____ BY _____
 Signature of person legally authorized to sign for patient/relationship

Prescriber Information

PRESCRIBER NAME (First, Last) _____ SPECIALTY _____
 PRACTICE NAME _____ OFFICE CONTACT _____
 ADDRESS _____
 CITY _____ STATE _____ ZIP CODE _____
 EMAIL _____ PHONE _____ FAX _____
 MEDICAID/MEDICARE PROVIDER# _____ TAX ID# _____
 STATE LICENSE# _____ UPIN/NPI# _____

Clinical Information

DIAGNOSIS 696.1 Psoriasis COMMENT/OTHER _____ TB EVALUATION Yes No
 DATE OF DIAGNOSIS OR YEARS WITH DISEASE _____ PATIENT WEIGHT _____ lb. _____ kg. % BSA AFFECTED _____
 PRIOR MEDICATIONS: Amevive* Corticosteroids Cyclosporine Enbrel* Humira* Methotrexate Raptiva*† Phototherapy Soriatane*

Nursing Orders (A Physician Plan of Treatment will be sent to prescriber for review and signature)

AccessOne® to coordinate subcutaneous injection through Alere®, an independently owned and operated nursing agency.

Administer STELARA™ 45 mg by subcutaneous injection Administer STELARA™ 90 mg by subcutaneous injection
 Starter Dose 1 (week 0) ASAP OR Date to initiate therapy _____ Starter Dose 1 (week 0) ASAP OR Date to initiate therapy _____
 Starter Dose 2 (4 weeks from Dose 1) Starter Dose 2 (4 weeks from Dose 1)
 Maintenance Dose (12 weeks from last dose) for _____ # of injections Maintenance Dose (12 weeks from last dose) for _____ # of injections

If nursing services are being requested after the initiation of therapy with STELARA™, date of last dose given _____

My signature certifies that I agree not to bill for any administration services that AccessOne® coordinates on my behalf.

PRESCRIBER SIGNATURE _____ DATE _____
 SUPERVISING PHYSICIAN SIGNATURE (if applicable) _____ NAME _____ DATE _____

Prescription Information (If requesting benefits investigation only, do not complete this section)

Rx STELARA™ 45 mg 90 mg
 DIRECTIONS: **STARTER DOSES** REQUESTED SHIP DATE _____ **MAINTENANCE THERAPY** REQUESTED SHIP DATE _____
 2 single-use prefilled syringes; 45 mg SC at Week 0 and Week 4 1 single-use prefilled syringe; 45 mg SC every 12 weeks Refills # _____
 2 single-use prefilled syringes; 90 mg SC at Week 0 and Week 4 1 single-use prefilled syringe; 90 mg SC every 12 weeks Refills # _____
 SHIP TO: PROVIDER OFFICE (If checked, AccessOne® cannot coordinate nursing services)
 PATIENT'S HOME
 OTHER ADDRESS _____
 CITY _____ STATE _____ ZIP CODE _____
 PHONE _____ FAX _____

PRESCRIBER SIGNATURE REQUIRED TO VALIDATE PRESCRIPTION

I certify that therapy with STELARA™ is medically necessary for this patient. I will be supervising the patient's treatment accordingly.

PRESCRIBER SIGNATURE _____ DATE _____
 SUPERVISING PHYSICIAN SIGNATURE (if applicable) _____ NAME _____ DATE _____

For assistance or additional information, call (888) ACCESS-1 (222-3771), Monday–Friday, 8:00AM–8:00PM, E.T.

*Indicated trademarks are registered trademarks of their respective owners. Amevive® (alefacept), Enbrel® (etanercept), Humira® (adalimumab), Raptiva® (efalizumab), Soriatane® (acitretin).

†On April 8, 2009, Raptiva voluntarily withdrew from the U.S. market.

Patient insurance benefit investigation is provided as a service by TheraCom, LLC, and The Lash Group, Inc., under contract for Centocor Ortho Biotech Inc. In this regard, TheraCom, LLC, and The Lash Group, Inc., assist healthcare professionals in the determination of whether treatment could be covered by the applicable third-party payer based on coverage guidelines provided by the payer and patient information provided by the healthcare provider under appropriate authorization following the providers' exclusive determination of medical necessity.

Importantly, insurance verification is the ultimate responsibility of the provider. Third-party reimbursement is affected by many factors. Therefore, TheraCom, LLC, The Lash Group, Inc., and Centocor Ortho Biotech, make no representation or guarantee that full or partial insurance reimbursement or any other payment will be available. This information is provided as an information service only. While TheraCom, LLC, and The Lash Group, Inc., try to provide correct information, they and Centocor Ortho Biotech, make no representations or warranties, expressed or implied, as to the accuracy of the information. In no event shall TheraCom, LLC, The Lash Group, Inc., or Centocor Ortho Biotech, or its employees or agents be liable for any damages resulting from or relating to the services. All providers and other users of this information agree that they accept responsibility for the use of this service.

Centocor Ortho Biotech assumes no responsibility for, and does not guarantee the quality, scope, or availability of the services including but not limited to reimbursement support services, coordination of prescription fulfillment, patient education, and other support services. Each provider, not Centocor Ortho Biotech, is responsible for the services they provide. These support services have no independent value to providers apart from the product and are included within the cost of the product.

Before prescribing STELARA™, please see Full Prescribing Information and Medication Guide for STELARA™, available at www.STELARAinfo.com.



Patient Copy

Provider Instructions

1. Have the patient read this form and sign the acknowledgements on the front of the Prescription Information, Nursing Order and STELARA™ Support Enrollment Form for STELARA™ (ustekinumab) relating to the Patient Authorization and STELARA™ Support Extended Services Enrollment.
2. Provide the patient with this sheet and a copy of the front of the Prescription Information, Nursing Order and STELARA™ Support Enrollment Form which they have signed.

PATIENT AUTHORIZATION (PA)

My signature on the front of the Prescription Information, Nursing Order and STELARA™ Support Enrollment Form confirms that I allow my prescriber(s), any other healthcare providers, specialty pharmacy providers (collectively "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 STELARA™ (ustekinumab) with Centocor Ortho Biotech Inc., its parent or affiliate, designee or successor, specialty pharmacies, providers of nursing services, providers of alternate sources of funding for prescription drug costs, and other service providers supporting AccessOne® for healthcare providers, or STELARA™ Support for patients (collectively, "Centocor Ortho Biotech"). AccessOne®, the Centocor Ortho Biotech support system, will provide services related to my use of STELARA™ (ustekinumab) including, but not limited to, reimbursement support services and coordination of prescription fulfillment (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 with 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 my information 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 inform 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 understand that I am not required to sign the front of the Prescription Information, Nursing Order and STELARA™ Support Enrollment Form. My choice about whether to sign will not change the way my healthcare providers or insurers treat me. If I refuse to sign the front of the Prescription Information, Nursing Order and STELARA™ Support Enrollment Form, or revoke my authorization later, I know that this means I will not be able to participate or receive assistance from AccessOne®.

STELARA™ SUPPORT EXTENDED SERVICES ENROLLMENT

By checking the appropriate boxes and signing the front of this Prescription Information, Nursing Order and STELARA™ Support Enrollment Form, I agree to enroll in the extended service(s) provided by the STELARA™ Support Program. STELARA™ Support will provide the extended services that I have chosen related to my use of STELARA™ (ustekinumab) including, but not limited to, patient education and other support services, for example, educational brochures and treatment reminder calls, emails, or text messages.

To support the extended services that you select, your name, address, and other information that you give us will be used by Centocor Ortho Biotech Inc., the marketer of STELARA™, and companies that work with Centocor Ortho Biotech, including other affiliates and parent companies, to support the Program. We will also use the information you give us to learn more about the patients who use STELARA™ and to improve the information we provide to patients who are being treated with STELARA™. Centocor Ortho Biotech will not share your information with anyone else except as stated above as required by law. If you want to stop receiving this information from Centocor Ortho Biotech, you may ask us to remove you from our contact list by calling 1-866-222-6410.

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.fda.gov/medwatch, or call 1-800-FDA-1088.

Please read the Medication Guide for STELARA™ and discuss any questions or concerns with your doctor.



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