Stelara withMe

Savings Program
866-708-8987
Monday–Friday, 8:00 AM–8:00 PM ET

Stelara® (ustekinumab)

Medical Benefit Rebate Form

Complete this form only if you are submitting an **Explanation of Benefits (EOB)** for a rebate check **to be sent directly to the patient.**

Receive a Rebate in 3 Easy Steps

1. Patient must complete the information below and sign the form.
2. Include a copy of the following documents:
   - Explanation of Benefits (EOB) from patient's primary insurance provider (as well as any secondary insurance provider, if applicable);
   - Receipt from the treatment provider indicating proof of payment of patient's out-of-pocket Janssen medication costs. Valid receipt will include patient name, medication (name, J code, or NDC#), date, and amount of out-of-pocket responsibility paid for patient's medication.

   If patient does not have proof of payment for the medication, patient must obtain their site representative's signature below.
3. Submit this form by mail along with EOB and proof of payment (see below for details). Eligible patients will receive a rebate check in about 3 weeks.

If you are submitting a **pharmacy receipt** and want to receive a rebate check, only complete the Pharmacy Benefit Rebate Form.

Complete the information below. *Required

The information you provide will only be used by Janssen Biotech, Inc., our affiliates, and our service providers to provide benefits to you related to your participation in the STELARA withMe Savings Program. If you want to stop receiving this information or service, you may withdraw from the program by calling 866-708-8987. Our Privacy Policy governs the use of the information you provide. By participating in the STELARA withMe Savings Program via Janssen CarePath, I am giving permission for information related to my Savings Program transactions, including rebates and any funds placed on or balance remaining on the Savings Program card, to be shared with my healthcare provider(s).

☐ By providing consent, you agree to the collection and use of your Sensitive Personal Information (SPI). Examples of SPI may include, but are not limited to, health-related information. We use this information consistent with our Privacy Policy, including to personalize the information you receive, fulfill any requests you submit, and to research, develop, and improve our products and services. By checking the box, you indicate that you read, understand, and agree to such collection and use of your SPI.

*Name _____ E-mail _____ *Phone _____

*11-digit ID# found on the front of the savings card _____ *Date of Birth (mm/dd/yyyy) _____ Gender ☐ Male ☐ Female

*Address _____ *City _____ *State _____ *ZIP _____

You may not seek payment for the value received from this program from any health plan, patient assistance foundation, flexible spending account, or healthcare savings account.

This program is only for people age 6 and older using commercial or private health insurance who must pay an out-of-pocket cost for their Janssen medication. This includes plans from the Health Insurance Marketplace. This program is not for people who use any state or federal government-funded healthcare program. Examples of these programs are Medicare, Medicaid, TRICARE, Department of Defense, and Veterans Administration.

You must meet the program requirements at the time of each Savings Program request. Program terms will expire at the end of each calendar year. The program may change or end without notice, including in specific states. Patients who are members of health plans (often termed "maximizer" or "optimizer" programs) that claim to reduce or eliminate their patients' out-of-pocket co-pay, co-insurance, or deductible obligations for certain prescription drugs based upon the availability of, or patient's enrollment in, manufacturer sponsored co-pay assistance for such drugs will have a $6,000 annual maximum program benefit per calendar year (not applicable to patients in Maine). If you have enrolled in one of these plans, please inform STELARA withMe at 866-708-8987. **To use this program, you must follow any health plan requirements, including telling your health plan how much co-payment support you get from this program. By getting a Savings Program benefit, you confirm that you have read, understood, and agree to the program requirements on this page, and you are giving permission for information related to your Savings Program transactions to be shared with your healthcare provider(s). These transactions include rebates and any funds placed on the card or balance remaining on the card.** Offer good only in the United States and its territories. Void where prohibited, taxed, or limited by law. REBATE FORM CANNOT BE BOUGHT, TRANSFERRED, OR SOLD. REBATE FORM CANNOT BE COMBINED WITH ANY OTHER OFFER, DISCOUNT, PRESCRIPTION SAVINGS CARD, OR FREE TRIAL. Use of this card is subject to the program requirements, which can be found on the STELARA withMe Savings Program Brochure.

By signing, dating, and submitting this form, you confirm that **you already enrolled in the STELARA withMe Savings Program and activated your Savings Program card before receiving your Janssen medication. STELARA withMe cannot process this rebate form if you have not completed this process.** In addition, you indicate you read, understand, agree, and meet the terms and conditions on this form, as well as the program requirements which were explained to you when you received the Savings Program card, which may also be found in the STELARA withMe Savings Program Brochure.

*Patient Signature _____ *Date _____

Site representative signature required ONLY if the rebate request is not accompanied by proof of payment and an Explanation of Benefits (EOB) statement for the below patient that indicates that they received STELARA® (ie, STELARA®, J3357, or J3358). By signing below, you are confirming the patient has paid for their out-of-pocket medication costs and was treated with STELARA® (J3357, J3358) on the date below.

*Site Representative Signature _____ *Print Name _____ *Date _____

*Treatment Site Name/Location _____ *Date of Treatment _____

You can submit by mail:

Mail:
STELARA withMe Savings Program
2250 Perimeter Park Drive, Suite 300
Morrisville, NC 27560

You will receive your rebate check in about 3 weeks.

Please read the full Prescribing Information and Medication Guide for STELARA® and discuss any questions you have with your doctor.

Clear Form Print Form