

To apply for assistance, complete this application, attach your most recent federal tax return and return by mail or fax.

Mail to: Patient Assistance Program, PO Box 220458, Charlotte, NC 28222-0458
 Telephone: 800-523-5870 Fax: 800-526-6651

PATIENT INFORMATION

Name _____ Guardian Name (if appropriate) _____
 Date of Birth _____ Gender Male Female Primary Telephone _____
 Social Security # _____ Alternate Telephone _____
 Address, City, State, ZIP _____

FINANCIAL INFORMATION (All Values Should Reflect Annual Amounts for Entire Household)

Salary/Wages/Unemployment \$ _____ Value of Assets \$ _____
 Pension/Social Security \$ _____ Other \$ _____
 Supplemental Security Income \$ _____ (Include: checking & savings accounts, certificates of deposit, stocks & bonds, mutual funds, IRAs, cash, and the value of life insurance policies if you turned in your policies for cash now. **Do not include: homes, vehicles, burial plots or personal possessions**)
 Social Security Disability Insurance \$ _____ Check the applicable box:
 Total Gross Annual Income \$ _____ **Attached is a copy of my most recent federal tax return**
 Household Size _____ **I do not file federal taxes**
 (Number of people who contribute to or are dependent on your household income)

INSURANCE INFORMATION

Do you have any public or private insurance? Yes No

Medicare Are you eligible for Medicare? Yes No
 If "No", will you be eligible for Medicare in the next 12 months? Yes No
 If "Yes", provide the date you will be eligible for Medicare _____
 Medicare Policy # _____
 Did Medicare benefits begin within the past 2 months? Yes No
 Are you enrolled in a Medicare prescription drug plan? Yes No
 Insurance Company _____ Plan Name / # _____
 Telephone _____ Policy ID # _____
 Are you eligible for the Low Income Subsidy for Medicare Part D? Yes No Unsure Application Pending

Medicaid Are you eligible for Medicaid? Yes No
 If "Yes", are you eligible for prescription drug benefits?
 Yes - Medicare Savings Program-Only (e.g., QMB, SLMB, QI-1)
 No - Spend-down not reached

Other State/Government Are you eligible for other state/government programs that provide prescription drug benefits (e.g., SPAP – State Patient Assistant Program)? Yes No Applied Not Applied
 Application Pending Waitlisted Unsure

Private/HMO Insurance Company _____ Telephone _____
 Policy ID # _____ Group ID # _____ Subscriber Name _____
 Does this policy cover prescription drugs? Yes No Date of Birth _____ Relation to Patient _____

APPLICANT DECLARING CHANGE IN INSURANCE COVERAGE

Johnson & Johnson Health Care Systems Inc. manages the ACIPHEX Patient Assistance Program on behalf of its affiliate PriCara, Unit of Ortho-McNeil, Inc., and Eisai Inc. the manufacturer of ACIPHEX®. Johnson & Johnson Health Care Systems Inc. is a duly authorized agent for Janssen Ortho Patient Assistance Foundation "JOPAF".
 "I understand that JOPAF policy requires individuals with access to medicines through an affordable benefit to seek access through that benefit. As such, I promise that I will notify Johnson & Johnson Health Care Systems Inc. and its Patient Assistance Program within 30 (thirty) days by mail at ACIPHEX Patient Assistance Program, P.O. Box 220458, Charlotte, NC 28222-0458, OR by telephone at 800-523-5870, OR by fax at 800-526-6651, if there is any change in the status of my eligibility to obtain any drug(s) that I will receive under this Patient Assistance Program through any other resource at any time during my participation in this Patient Assistance Program. I understand that this notification requirement would apply to circumstances including, but not limited to, changes in my eligibility to participate in the Medicare program [due to changes in my age (65+) or disability status (including end-stage renal disease)], or my enrollment in the Medicare Part D prescription drug benefit."

Please indicate your agreement with these terms by signing below.

Patient Signature _____ Date _____

APPLICANT DECLARING ACCURATE & COMPLETE INFORMATION

"I promise that the information on this form is correct and complete. If needed, Johnson & Johnson Health Care Systems Inc. and its 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."

Please indicate your agreement with these terms by signing below.

Patient Signature _____ Date _____

Complete this form and return by mail or fax. The Program needs to receive both the patient and physician information in order to process the application.

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Patient Name _____

PHYSICIAN INFORMATION

Physician Name _____ Telephone _____ Fax _____

Facility Name _____ Tax ID # _____

Business Hours _____ Office Contact Name _____ Medicare Provider ID # _____ National Provider ID # _____

Address City, State, ZIP _____

PRESCRIBING INFORMATION

Patient Name _____ Product Name ACIPHEX® (rabeprazole sodium) _____

Dosage 20 mg. tablets _____ Sig _____ Quantity _____ (90 Day Max/Per Shipment) Date _____

Number of Refills _____ State License # (required) _____

Physician DEA # (required) _____

To the best of my knowledge, this patient does not have prescription drug insurance coverage (including Medicaid, county funded, or other public programs) for the product(s) listed above. Johnson & Johnson Health Care Systems Inc. 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 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 Signature _____

AUTHORIZATION TO SHARE HEALTH INFORMATION FOR PATIENT ASSISTANCE PROGRAM

Patients must complete this form before they can participate in the Patient Assistance Program.

I, _____, allow my doctor(s), any other health care providers, and my health plan or insurers to give medical information relating to my use or need for ACIPHEX® (rabeprazole sodium) to Lash Group. Lash Group runs the ACIPHEX® Patient Assistance Program (the “Program”) for Johnson & Johnson Health Care Systems Inc. Johnson & Johnson Health Care Systems Inc. manages the ACIPHEX® Patient Assistance Program on behalf of its affiliate PriCara, Unit of Ortho-McNeil, Inc., and Eisai Inc. the manufacturer of ACIPHEX®. ACIPHEX® is manufactured and marketed by Eisai Inc. and marketed by PriCara, Unit of Ortho-McNeil, Inc.

This information can include spoken or written facts about my health and payment benefits. It can include copies of records from my health care providers or health plans about my health or health care. Lash Group and Johnson & Johnson Health Care Systems Inc. will use and give out this information to see if I qualify for the Program and to run the Program. People who work for and with Lash Group, Johnson & Johnson Health Care Systems Inc. and Eisai Inc. may also see my information, but they may use it only to help me get assistance with the costs of my drugs and to operate the Program.

I understand that they will make every effort to keep my information private, but if it is accidentally given out, federal privacy laws will not protect it.

This Authorization will last until I am no longer participating in the Program. If I change my mind before that time, I can tell my health care providers and my insurers in writing that I do not want them to share any more information with Lash Group or Johnson & Johnson Health Care Systems Inc., and Eisai Inc. but it will not change any actions they took before I told them. I know that I have a right to see or copy the information my health care providers or insurers have given to Lash Group, Johnson & Johnson Health Care Systems Inc., and Eisai Inc.

I KNOW THAT I MAY REFUSE TO SIGN THIS FORM.

My choice about whether to sign this form will not change the way my health care providers or insurers treat me. If I refuse to sign this form, I know that this means I may no longer be able to receive assistance from the Program.

Patient Name (Print) _____ Date _____

Patient Signature _____

If the patient cannot sign, patient’s personal representative must sign below.

Patient Representative Signature _____

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

A copy of this form must be provided to the patient.