

**Johnson & Johnson Patient Assistance Foundation, Inc.
Hospital Access Patient Assistance Program**

Please complete each section to the fullest extent possible. If an item does not apply, please note "N/A" on that line. If you require additional space you may attach additional sheets of paper.

Please return this complete form to:

Mail: Johnson & Johnson Patient Assistance Foundation Hospital Access Patient Assistance Program
PO Box 220455
Charlotte, NC 28222-0455
Telephone: (800) 652-6227
Fax: (800) 521-2437

New Application _____

Re-Application _____

AVAILABLE PRODUCTS

ORAL FORMULATIONS ONLY

Ditropan® XL (oxybutynin chloride) Tablets
Edurant™ (rilivrine) Tablets
Intelence® (etravirine) Tablets
Invega® (paliperidone) Extended-Release Tablets
Levaquin® (levofloxacin) Tablets
Prezista® (darunavir) Tablets
Risperdal® (risperidone) Tablets
Risperdal® (risperidone) Oral Solution
Risperdal® (risperidone) M-TAB
Topamax® (topiramate) Tablets
Topamax® (topiramate) Sprinkle Capsules
Ultracet® (tramadol hydrochloride/acetaminophen) Tablets
Xarelto® (rivaroxaban)

INFUSION/INJECTION ONLY

Doxil® (doxorubicin HCl liposome injection) for intravenous infusion
Procrit® (Epoetin alfa) FOR INJECTION
(Dialysis patients receiving Procrit are not eligible for the Program)

FACILITY INFORMATION

Name of person completing application: _____ Title: _____
Responsible site contact name: _____ Title: _____
Facility Name: _____
Street Address: _____ City, State Zip: _____
Tel: (_____) _____ Fax: (_____) _____

SHIP TO ADDRESS OF OUTPATIENT PHARMACY

Facility Name: _____
Ship to Contact Name: _____ Title: _____
Street Address: _____ City, State Zip: _____
Tel: (_____) _____ Fax: (_____) _____
Facility State License Number: _____ Facility DEA Number: _____

ADDITIONAL FACILITY INFORMATION

Does your facility:

- Have Disproportionate Share Hospital (DSH) Status?
 YES NO
- Have an Outpatient Pharmacy where product can be stored?
 YES NO
- Participate in the 340B Drug Pricing Program?
 YES NO
- Have DRG-Exemption?
 YES NO

APPLICANT DECLARATION

To the best of my knowledge, the information provided is accurate and correct. Johnson & Johnson Patient Assistance Foundation, Inc. (JJPAF) 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 or administration of 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 patients treated with product through this program.

Signature (Responsible Site Contact): _____ Date: _____