

## Rebate Form

Submit this form if your pharmacy or doctor's office can't process your Janssen CarePath Savings Program card.



### STEP 1

You must be enrolled in the Janssen CarePath Savings Program before filling your prescription. You can enroll online at [MyJanssenCarePath.com/express](https://MyJanssenCarePath.com/express).

### STEP 2

Use your card to complete the information on the next page. Sign the form.

### STEP 3

Include a copy of the pharmacy receipt (cash register receipts not accepted). Valid receipt will include your name, medication, date, and amount paid for your Janssen medication.

**OR**

Include the original Explanation of Benefits (EOB) from your insurance company with proof of payment for your Janssen medication.

### STEP 4

Mail this signed form along with your pharmacy receipt or EOB and a copy of your Savings Program card to the address on the next page. Eligible patients will receive a rebate check.

Please read the full [Prescribing Information](#), including **Boxed WARNING**, for RISPERDAL CONSTA<sup>®</sup>, and discuss any questions you have with your doctor.

# Rebate Form

## RISPERDAL CONSTA® (risperidone)

**Read instructions on previous page**, then complete the information below.

The information you provide will only be used by Janssen Pharmaceuticals, Inc., the maker of RISPERDAL CONSTA®, our affiliates, and our service providers, to provide benefits to you related to the use of your Janssen CarePath Savings Program card. If you want to stop receiving this information or service, you may withdraw from the program by calling 866-562-6177. Our [Privacy Policy](#) governs the use of the information you provide.

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.

**\*Required**

\*Name

\*Gender  M  F

\*Date of Birth (mm/dd/yyyy)

\*Address

\*City

\*State

\*ZIP Code

\*E-mail

\*Phone

\*11-digit Savings Program ID # found on the front of the card

**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 available to people age 18 or older using commercial or private health insurance 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.

**Your eligibility to use the Savings Program card is subject to meeting the program requirements at the time of each use.** Program terms will expire at the end of each calendar year. The program may change or end without notice, including in specific states. **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 using the Savings Program card, 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 at [RisperdalConsta.JanssenCarePathSavings.com](https://www.RisperdalConsta.JanssenCarePathSavings.com).

By signing, dating, and submitting this form, you confirm that **you already enrolled in the Janssen CarePath Savings Program and received your savings card before receiving your Janssen medication. Janssen CarePath 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 card, which may also be found at [RisperdalConsta.JanssenCarePathSavings.com](https://www.RisperdalConsta.JanssenCarePathSavings.com).

\*Signature

\*Date

[Questions?](#) Call 866-562-6177, Monday–Friday, 8:00 AM–8:00 PM ET

**Mail to:** Janssen CarePath 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](#), including **Boxed WARNING**, for RISPERDAL CONSTA®, and discuss any questions you have with your doctor.**