COMPLETION OF THIS FORM IS VOLUNTARY. YOU DO NOT NEED TO SIGN THIS IN ORDER TO GET YOUR MEDICATION.

+P.L.U.S.™ PROGRAM
Patient Learning | Understanding | Support

The *P.L.U.S.™ Program* Authorization Form

offered by *Actelion Pathways®*

Mail to:
ACTELION PHARMACEUTICALS US, INC.
PO BOX 3071
WARMINSTER PA 18974-9711

Fax to: 1-888-797-4477

By completing this form, you understand and agree that you will automatically be enrolled to receive additional offerings from *Actelion Pathways* including information about: pulmonary arterial hypertension (PAH), Actelion treatment options, patient support programs, and PAH-related special events. Additionally, you understand and agree that you also will automatically be enrolled in the *P.L.U.S. (Patient Learning, Understanding, and Support) Program*, including receiving information for the Actelion medication you have been prescribed.

***Required**

Please complete this section to enroll in the *P.L.U.S. Program*

*Name: _____ *Street Address: _____
FIRST LAST

*City: _____ *State: _____ *Zip Code: _____

Email: _____ *Phone: _____

***Which best describes you?** ☐ I have PAH ☐ I'm a family member/friend/caregiver of someone with PAH

Age: ☐ 18-28 ☐ 29-38 ☐ 39-48 ☐ 49-58 ☐ 59-68 ☐ 69+ Sex: ☐ M ☐ F Date of PAH diagnosis (MM/YY): ____/____

Tell us how you feel about the following statements:

I believe that medication can help my PAH.

☐ Strongly agree ☐ Agree ☐ Uncertain ☐ Disagree ☐ Strongly disagree

I feel I have an adequate understanding of how PAH affects me.

☐ Strongly agree ☐ Agree ☐ Uncertain ☐ Disagree ☐ Strongly disagree

Treatment information:

☐ Current medication(s) for PAH: _____

☐ Past medication(s) for PAH: _____

☐ Never treated for PAH

Request communications about any of the following Actelion services:

☐ Opportunities to share your story (ie, potential participation in videos, brochures, etc)**

☐ Participation in market research (your feedback could improve patient materials)**

☐ Participation in clinical trials**

**You may be contacted to determine if you would like to participate in one of these channels. This consent is to receive these offers only. You must qualify for participation, and a separate agreement would be necessary prior to any actual participation.

***Required**

By signing this form and submitting your information, you acknowledge and agree that you are voluntarily providing us with your personal information. Actelion respects your personal health information. The information you provide may be used to send you health-related materials and to develop or improve products, services, and programs. Actelion, or third parties working on our behalf, will not sell or rent your personal health information. Please visit **ActelionPathways.com/pdf/PrivacyPolicy.pdf** to review our Privacy Policy.

By signing here you agree to receive information from Actelion.

***Signature** _____ **Date** _____

Complete and sign the authorization form where indicated; then mail or fax back to the address or phone number at the top of the page.