Janssen CarePath

Uptravi selexipag tablets | 200-1600 mcg

UPTRAVI® Prescription and Statement of Medical Necessity (PSMN)

FAX COVER SHEET

Date: _____

To: Janssen CarePath Fax number: **866-279-0669**

From: _____

Facility name: _____

Facility contact: _____

Completed UPTRAVI® Prescription and Statement of Medical Necessity (PSMN) enclosed.

Number of pages (including cover): _____

Specialty pharmacy preference: ☐ Accredo ☐ CVS/specialty

Comments: _____

_____

_____

_____

_____

_____

Contact Janssen CarePath at 866-228-3546.

If you do not wish to receive any future faxes from Janssen CarePath, call 866-228-3546, Monday through Friday, 8:00 AM to 8:00 PM ET, or by fax at 866-279-0669. Your request will not be honored if (i) it is not made to the phone or fax number listed; (ii) it fails to identify the telephone number(s) at which you no longer wish to receive faxes; or (iii) subsequent to your request, you provide express invitation or permission to the sender, in writing or otherwise, to send such communications to you. The sender's failure to comply with an opt-out request within 30 days is unlawful.

CONFIDENTIALITY NOTE

The documents accompanying this telecopy transmission contain confidential or privileged information. The information is intended to be for the use of the individual or entity named on this transmission sheet. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this telecopied information is prohibited. If you have received this telecopy in error, please notify Janssen CarePath at 866-228-3546 immediately so we can arrange for the retrieval of the original document at no cost to your office. Thank you for your assistance.

UPTRAVI® tablet strengths: 200, 400, 600, 800, 1000, 1200, 1400, and 1600 mcg

Please see the full Prescribing Information and Patient Product Information for UPTRAVI®. Provide the Patient Product Information to your patients and encourage discussion.

Janssen CarePath

UPTRAVI® Prescription and Statement of Medical Necessity (PSMN)

Uptravi selexipag tablets | 200-1600 mcg

Complete this form for all patients. Complete all ★REQUIRED fields in this form. Patients to complete and sign section 8 (pages 2 and 3) or submit a digital version of the Janssen Patient Support Program Patient Authorization at PAHconsent.com.

Fax completed form and copy of patient's insurance card to 866-279-0669 and/or include copy of patient demo from electronic medical records. Please provide copies of all medical and prescription insurance cards (front and back).

The information you provide will be used by Actelion Pharmaceuticals US, Inc., a Janssen Pharmaceutical Company, our affiliates, or our service providers to fulfill your requests. Our Privacy Policy further governs the use of the information you provide. By completing and submitting this form, you indicate that you read, understand, and agree to these terms.

1 Patient Information (please print)

★(REQUIRED) **First name** | MI | ★(REQUIRED) **Last name**

★(REQUIRED) **Birth date** (MM/DD/YYYY) | Gender: ☐ Male ☐ Female | Preferred language: ☐ English ☐ Spanish | Email address

★(REQUIRED) **Primary phone #** | Cell phone # or ☐ check if same as primary | Best time to call

★(REQUIRED) **Address** | ★(REQUIRED) **City** | ★(REQUIRED) **State** | ★(REQUIRED) **ZIP**

Legally authorized representative name | Relationship | Phone #

Is patient starting UPTRAVI® in a hospital setting? ☐ Yes ☐ No

2 UPTRAVI® Tablets Prescription Information

★(REQUIRED) **Please select the following titration dosing order or provide alternate dosing instructions below.**

☐ **Strength:**

Shipment 1: 200 mcg (NDC 66215-602-14 for 140-count bottle)

Shipment 2: 200 mcg and 800 mcg (NDC 66215-628-20 for titration pack containing one 140-count 200 mcg bottle and one 60-count 800 mcg bottle)

Dosage/Directions: 200 mcg BID by mouth for 1 week, then increase by 200 mcg BID, usually at weekly intervals (as tolerated), up to 1600 mcg BID or the preferred maintenance dose

Dispense: Quantity up to 30-day supply **Titration refills:** _____

Maintenance dose: Contact healthcare provider for prescription

- OR -

☐ **Alternate dosing instructions:** _____

3 Shipping

Ship to: ☐ Patient home ☐ Prescriber office ☐ Other

Other Address | City | State | ZIP

4 Nurse Support†

☐ Please check this box if you would like your patient to **receive nurse-supported† patient education on administration, dosing and titration of UPTRAVI®** and/or their disease. Nurse support† is available to patients during their dose adjustment (titration) phase.

†Nurse support is limited to education for patients about their Janssen therapy, its administration, and/or their disease. It is intended to supplement a patient's understanding of their therapy, and is not intended to provide medical advice, replace a treatment plan from the patient's doctor or nurse, directly provide case management services, or serve as a reason to prescribe. Program rules and limitations will apply.

5 Prescriber Information (please print)

★(REQUIRED) **Prescriber's full name** | Site name

★(REQUIRED) **Address** | ★(REQUIRED) **City** | ★(REQUIRED) **State** | ★(REQUIRED) **ZIP**

Office contact name | ★(REQUIRED) **Office contact phone #** | Office contact email address | Fax #

NPI # | State license #

6 Prescriber Signature

★(REQUIRED) I have made the determination, based on my independent clinical judgment, that the medication ordered is medically necessary for the patient for the intended use. I am personally supervising the care of this patient. I certify that the requested additional nurse support is necessary beyond the support my office has already provided. I authorize Actelion Pharmaceuticals US, Inc., a Janssen Pharmaceutical Company, its affiliates, agents, and contractors to act on my behalf for the limited purposes of transmitting this prescription to the appropriate pharmacy designated by the patient utilizing their benefit plan. This authorization includes permitting Janssen to communicate to payers on my behalf to confirm this patient's health plan eligibility and benefits. **PRESCRIBER SIGNATURE REQUIRED TO VALIDATE PRESCRIPTIONS. Prescriber attests this is his/her legal signature (NO STAMPS). Prescriptions must be faxed.**

Prescriber signature (Dispense as Written) | **Prescriber signature** (Substitution Allowed) | **Date**

The prescriber is to comply with their state-specific prescription requirements, such as e-prescribing, state-specific prescription form, fax language, etc. Noncompliance with state-specific requirements could result in outreach to the prescriber.

7 Diagnosis

★(REQUIRED) **The following ICD-10 codes do not suggest approval, coverage, or reimbursement for specific uses or indications. (Check the box for the appropriate code below.)**

ICD-10 I27.0
Primary pulmonary hypertension

☐ **Idiopathic PAH**

☐ **Heritable PAH**

ICD-10 I27.21
Secondary PAH associated with:

☐ **Connective tissue disease**

☐ **Congenital heart disease**

☐ **Drugs/toxins induced**

☐ **HIV**

☐ **Other:**

_____

_____

Please see the full Prescribing Information and Patient Product Information for UPTRAVI®. Provide the Patient Product Information to your patients and encourage discussion.

8 Janssen Patient Support Program Patient Authorization

Patients should **(1)** read the Patient Authorization, **(2)** check the desired permission boxes, and **(3)** return the form to Janssen Patient Support Program.

Options to complete and return the form:

A. Download a copy, print, check the desired boxes, and sign. The completed form may be faxed to 866-279-0669 or mailed to Janssen CarePath, PO Box 826, South San Francisco, CA 94083.

B. Patients may also read, sign, and submit a digital version of this form at **PAHconsent.com**.

Patient name: _____

Email address: _____

I give permission for each of my "Healthcare Providers" (eg, my physicians, pharmacists, specialty pharmacies, other healthcare providers and their staff) and "Insurers" (eg, my health insurance plans) to share my Protected Health Information.

My "Protected Health Information" includes but is not limited to the following information related to my medical condition, treatment, prescriptions, and health insurance coverage.

The following person(s) or class of person(s) are given permission to receive and use my Protected Health Information (collectively "Janssen"):

- Johnson & Johnson Health Care Systems Inc., its affiliated companies, agents, and representatives
- Providers of other sources of funding include foundations and co-pay assistance providers
- Service providers supporting or analyzing data from Janssen patient support programs

Specifically, I give permission to Janssen to receive, use, and share my Protected Health Information in order to:

- see if I qualify for, sign me up for, and contact me about Janssen patient support programs
- manage the Janssen patient support programs
- give me educational and adherence materials, information, and resources related to my Janssen medication in connection with Janssen patient support programs
- communicate with my Healthcare Providers regarding access to, reimbursement for and fulfillment of my Janssen medication, and to confirm to my Healthcare Provider that support has been provided by the Janssen patient support programs
- verify, assist with, and coordinate my coverage for my Janssen medication with my Insurers and Healthcare Providers
- coordinate prescription or treatment location and associated scheduling
- conduct analysis to help Janssen evaluate, create and improve its products, services, and customer support for patients prescribed Janssen medications
- share and give access to information created by the Janssen patient support programs that may be useful for my care

I understand that my Protected Health Information may be shared by Janssen for the uses written in this Form to:

- My Insurers
- My Healthcare Providers
- Any of the persons given permission to receive and use my Protected Health Information as mentioned above
- Any individual I give permission as an additional contact

continued next page

8 Janssen Patient Support Program Patient Authorization (cont'd)

I understand that my Protected Health Information will not be used or shared by Janssen for any other use without my permission. Janssen may share information about me where legally allowed or if any information that specifically identifies me is removed. I understand that Janssen will make every effort to keep my information private. Further, I understand that if my information is accidentally shared, federal privacy laws do not require that the person/party receiving it not share the information further and that such information provided to a third party may no longer be protected by federal privacy laws. I understand that my pharmacy may receive compensation in connection with sharing my information with Janssen as allowed under this Authorization.

I understand that I am not required to sign this Form. My choice about whether to sign will not change how my Healthcare Providers or Insurers treat me. If I do not sign this Form, or cancel or remove my permission later, I understand I will not be able to participate or receive assistance from Janssen's patient support programs.

This Form will remain in effect 10 years from the date of signature, except where state law requires a shorter time, or until I am no longer participating in any Janssen patient support programs. Information collected before that date may continue to be used for the purposes set forth in this Form.

I understand that I may cancel the permissions given by this Form at any time by letting Janssen know in writing at: Janssen CarePath, PO Box 826, South San Francisco, CA 94083

I can also cancel my permission by letting my Healthcare Providers and Insurers know in writing that I do not want them to share any information with Janssen.

I further understand that if I cancel my permission it will not affect how Janssen uses and shares my Protected Health Information received by Janssen prior to my cancellation.

I understand I may request a copy of this Form.

Permission for communications outside of Janssen patient support programs:

☐ Yes, I would like to receive communications relating to my Janssen medication.

☐ Yes, I would like to receive communications relating to other Janssen products and services.

For privacy rights and choices specific to California residents, please see Janssen's California **privacy notice**

Permission for text communications:

☐ Yes, I would like to receive text messages. By selecting this option, I agree to receive text messages as allowed by this form to the cell phone number provided below. Message and data rates may apply. Message frequency varies. I understand I am not required to provide my permission to receive text messages to participate in the Janssen patient support programs or to receive any other communications I have selected.

Cell phone number: _____

Patient sign here: _____ **Date:** _____

If patient cannot sign, patient's legally authorized representative must sign below:

By: _____ **Print name:** _____ **Date:** _____

(Signature of person legally authorized to sign for patient)

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

_____

janssen