

withMe OPSUMIT® (macitentan) Enrollment and Prescription Form**Complete this form for ALL patients.****1. Forward this completed Enrollment and Prescription Form to the VA Pharmacy.****2. The VA Pharmacy will fax the completed Enrollment and Prescription Form to J&J withMe at 866-279-0669.****Contact J&J withMe at 866-228-3546 for Enrollment and Prescription Form questions.**

Johnson & Johnson Health Care Systems Inc., our affiliates, our service providers, the Veterans Health Care Administration, your specialty pharmacy or pharmacies, and your health plans will use the information you provide to fill your prescription and to provide other services you may select.

Fields marked with an (*) are required.**1 Patient Information** (please print)

*First name	*Last name	*Birth date	<input type="checkbox"/> Male <input type="checkbox"/> Female
		*Sex at birth	
Address	City	State	ZIP
*Primary phone #	Alternate phone #	Best time to call	

2 Prescriber Information (please print)

*First name	*Last name
Practice/Site name	Specialty
Address	City State ZIP
Phone #	Fax #
*Prescriber NPI	

3 Prescription and Shipping Information (please print)***(REQUIRED) Please check only one box in this section.** The following ICD-10 codes do not suggest approval, coverage, or reimbursement for specific uses or indications.**ICD-10 127.0 Primary pulmonary hypertension**

- ☐ Idiopathic PAH
☐ Heritable PAH

ICD-10 127.21 Secondary PAH associated with:

- ☐ Connective tissue disease ☐ Congenital heart disease with repaired shunts
☐ Drugs/toxins induced

☐ Other: Complete only if no ICD-10 code checked**OPSUMIT® (macitentan) 10 mg once daily for oral administration NDC 66215-501-30**

Quantity: _____ Refills: _____

Alternate instructions for use (if needed): _____

Ship to: ☐ Patient home ☐ VA pharmacy

Address _____ City _____ State _____ ZIP _____

Payment Method: ☐ Credit Card (call pharmacy contact) ☐ E-InvoiceTungsten Network**Purchase Order #:** _____

VA pharmacy Primary purchasing contact:	Phone #	Fax #	Email
VA pharmacy Primary clinical contact:	Phone #	Fax #	Email
VA pharmacy Secondary purchasing contact:	Phone #	Fax #	Email
VA pharmacy Secondary clinical contact:	Phone #	Fax #	Email

4 Prescriber Signature – Prescription and Statement of Medical Necessity

I have made the determination, based on my independent clinical judgment, that the medicine ordered is medically necessary for the patient for the intended use. I am personally supervising the care of this patient. I authorize Johnson & Johnson Health Care Systems Inc., 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 J&J 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.**

***SIGN HERE**

Dispense as Written

OR

Substitution Allowed

Date _____

5 Fax Requirements**Once you've completed this form:****1. Forward this completed Enrollment and Prescription Form to the VA Pharmacy.****2. The VA Pharmacy will fax the completed Enrollment and Prescription Form to J&J withMe at 866-279-0669.****Contact J&J withMe at 866-228-3546 for Enrollment and Prescription Form questions.**

The patient support and resources provided by J&J withMe are not intended to provide medical advice, replace a treatment plan from the patient's doctor or nurse, provide case management services, or serve as a reason to prescribe OPSUMIT®.

Please read full Prescribing Information, including BOXED WARNING, and Medication Guide for OPSUMIT®. Provide the Medication Guide to your patients and encourage discussion.

Clear Form

Print Form