J&J withMe

Uptravi selexipag tablets | 200-1600 mcg

Guide to Completing the UPTRAVI® Enrollment and Prescription Form

Once a decision has been made to prescribe UPTRAVI®, use the Enrollment and Prescription Form to get your patient started on treatment with UPTRAVI®.

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 UPTRAVI®.

Information about your patient's insurance coverage, cost support options, and treatment support is given by service providers for J&J withMe. The information you get does not require you or your patient to use any Johnson & Johnson product. Because the information we give you comes from outside sources, J&J withMe cannot promise the information will be complete.

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

Enrollment and Prescription Form Fax Cover Sheet

Complete and submit the Fax Cover Sheet along with the Enrollment and Prescription Form

- Follow these instructions when submitting the Enrollment and Prescription Form to reduce potential delays in getting your patient started on treatment
- Pay special attention to the requirements for Patient Authorization

This section provides information on Access, Affordability, and Treatment Support included in J&J withMe for patients.

UPDATE 04.25

J&J withMe

Enrollment and Prescription Form Fax Cover Sheet

Uptravi selexipag tablets | 200 | 600 mcg

Fax the following to J&J withMe at 866-279-0669:

1. UPTRAVI® Enrollment and Prescription Form, including the Johnson & Johnson Patient Support Program Patient Authorization
2. Please provide copies of all medical and prescription insurance cards (front and back)
3. If needed, please attach list of concomitant medicines
4. If needed, please attach list of known drug allergies

Patient Authorization Requirements

Patients to complete and sign all pages of the attached Patient Support Program Patient Authorization Form. Please fax the completed and signed Patient Authorization with the UPTRAVI® Enrollment and Prescription Form. If necessary, a patient can submit a digital version of the Patient Authorization at **PAHconsent.com** or by scanning the QR code.

Data rates may apply.

Fax the completed and signed Enrollment and Prescription Form to J&J withMe at 866-279-0669. You can also request benefits investigations on the Provider Portal at PATHwatch.net.

Once a decision has been made to prescribe UPTRAVI® and your patient has signed the Patient Authorization form

J&J withMe is a suite of access, affordability, and treatment support resources for your patients

Access Support to help navigate payer processes by verifying insurance coverage, determining requirements for approval, and providing reimbursement information.

Affordability Support to help your patients start and stay on the UPTRAVI® you prescribe by providing affordability options that may be available.

Treatment Support, including PAH Companion withMe, to help your patients get informed and stay on prescribed UPTRAVI®.

If you have questions, call a J&J withMe Care Coordinator at 866-228-3546, Monday–Friday, 8:00 AM–8:00 PM ET. Multilingual phone support available. Visit JNJwithMe.com.

cp-136372v7

Date: _____

Fax number: **866-279-0669**

From: _____

Facility name: _____

Facility contact: _____

Completed UPTRAVI® Enrollment and Prescription Form enclosed.

Number of pages (including cover): _____

Specialty Pharmacy preference: ☐ Accredo Health Group, Inc. ☐ CVS/specialty

Please note: The Specialty Pharmacy preference above will be validated through the standard benefit verification process. Other factors, like payer mandates, will ultimately determine where the enrollment is sent.

Comments: _____

Contact J&J withMe at 866-228-3546.

The patient support and resources provided by J&J withMe and PAH Companion 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 a J&J medicine.

Information about your patient's insurance coverage, cost support options, and treatment support is given by service providers for J&J withMe. The information you get does not require you or your patient to use any Johnson & Johnson product. Because the information we give you comes from outside sources, J&J withMe cannot promise the information will be complete.

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

- Complete the requested fields
- If you have a preferred Specialty Pharmacy, please check the appropriate box. Keep in mind that the patient's insurer will make the final decision on which pharmacy will dispense UPTRAVI®

Need help?

If you have any questions, contact

J&J withMe at 866-228-3546

Monday through Friday, 8:00 AM to 8:00 PM ET

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

Enrollment and Prescription Form

Please complete all *(REQUIRED) fields and print clearly to avoid processing delays

1. Patient Information

- Complete all ***(REQUIRED)** fields
- If patients select “Spanish” or “Other” as their preferred language, J&J withMe will communicate with the patient in their chosen language whenever possible
- Checking one of the boxes to designate a Care Partner or legally authorized representative to receive communications from J&J withMe on the patient’s behalf helps prevent delays to therapy. Remember to include the name, phone number, and email address for the designated contact
- Fill in the patient’s insurance information and attach a copy of the patient’s medical and prescription insurance cards. Otherwise, J&J withMe will need to reach out to the patient for this information, which can delay processing by 1 or more days

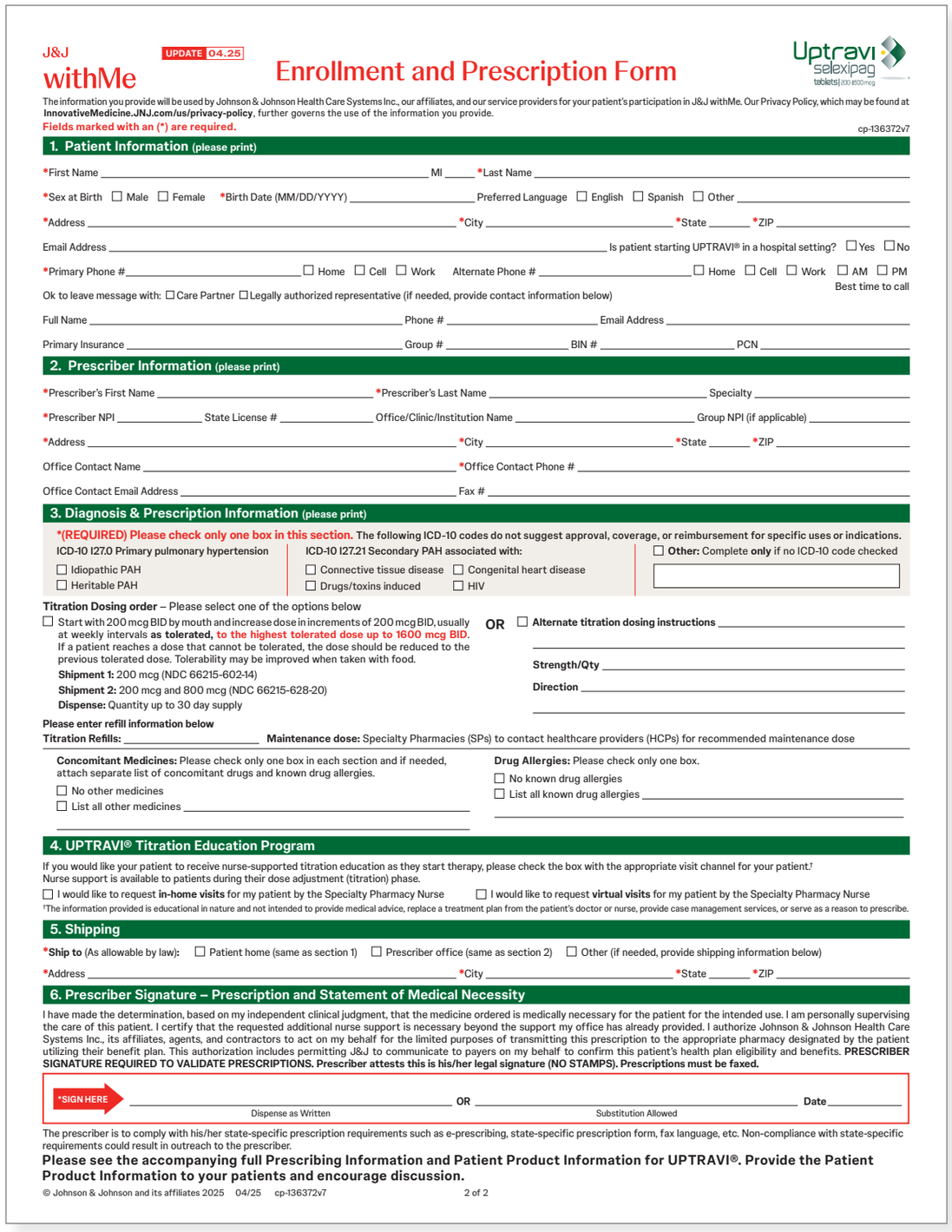
2. Prescriber Information

- Complete all ***(REQUIRED)** fields
- Provide your State License number and Office/Clinic/Institution name to ensure your patient is aligned to the correct facility and reduce potential delays in getting the patient started on treatment

3. Diagnosis & Prescription Information

- Check the appropriate box for the patient’s diagnosis. Remember to check only one box
- Check the appropriate box for Titration Dosing order. Only select one option
- If selecting “Alternate titration dosing instructions,” please provide adequate instructions for the Specialty Pharmacy
- Enter titration refill quantity

If checking the box for “Concomitant Medicines” and/or “Drug Allergies,” attach a separate list if there is not enough space to include on the form. This will help reduce delays to therapy.



J&J withMe UPDATE 04.25

Enrollment and Prescription Form

Uptravi selexipag tablets

The information you provide will be used by Johnson & Johnson Health Care Systems Inc., our affiliates, and our service providers for your patient’s participation in J&J withMe. Our Privacy Policy, which may be found at **InnovativeMedicine.JNJ.com/us/privacy-policy**, further governs the use of the information you provide.

Fields marked with an (*) are required.

cp-136372v7

1. Patient Information (please print)

*First Name _____ MI ____ *Last Name _____

*Sex at Birth ☐ Male ☐ Female *Birth Date (MM/DD/YYYY) _____ Preferred Language ☐ English ☐ Spanish ☐ Other _____

*Address _____ *City _____ *State _____ *ZIP _____

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

*Primary Phone # _____ ☐ Home ☐ Cell ☐ Work Alternate Phone # _____ ☐ Home ☐ Cell ☐ Work ☐ AM ☐ PM Best time to call

Ok to leave message with: ☐ Care Partner ☐ Legally authorized representative (if needed, provide contact information below)

Full Name _____ Phone # _____ Email Address _____

Primary Insurance _____ Group # _____ BIN # _____ PCN _____

2. Prescriber Information (please print)

*Prescriber’s First Name _____ *Prescriber’s Last Name _____ Specialty _____

*Prescriber NPI _____ State License # _____ Office/Clinic/Institution Name _____ Group NPI (if applicable) _____

*Address _____ *City _____ *State _____ *ZIP _____

Office Contact Name _____ *Office Contact Phone # _____

Office Contact Email Address _____ Fax # _____

3. Diagnosis & Prescription 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 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:** Complete **only** if no ICD-10 code checked

Titration Dosing order – Please select one of the options below

☐ Start with 200 mcg BID by mouth and increase dose in increments of 200 mcg BID, usually at weekly intervals **as tolerated, to the highest tolerated dose up to 1600 mcg BID**. If a patient reaches a dose that cannot be tolerated, the dose should be reduced to the previous tolerated dose. Tolerability may be improved when taken with food.
Shipment 1: 200 mcg (NDC 66215-602-14)
Shipment 2: 200 mcg and 800 mcg (NDC 66215-628-20)
Dispense: Quantity up to 30 day supply

OR ☐ **Alternate titration dosing instructions** _____

Strength/Qty _____

Direction _____

Please enter refill information below

Titration Refills: _____ **Maintenance dose:** Specialty Pharmacies (SPs) to contact healthcare providers (HCPs) for recommended maintenance dose

Concomitant Medicines: Please check only one box in each section and if needed, attach separate list of concomitant drugs and known drug allergies.
☐ No other medicines
☐ List all other medicines _____

Drug Allergies: Please check only one box.
☐ No known drug allergies
☐ List all known drug allergies _____

4. UPTRAVI® Titration Education Program

If you would like your patient to receive nurse-supported titration education as they start therapy, please check the box with the appropriate visit channel for your patient.†
Nurse support is available to patients during their dose adjustment (titration) phase.

☐ I would like to request **in-home visits** for my patient by the Specialty Pharmacy Nurse ☐ I would like to request **virtual visits** for my patient by the Specialty Pharmacy Nurse

†The information provided is educational in nature and 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.

5. Shipping

***Ship to** (As allowable by law): ☐ Patient home (same as section 1) ☐ Prescriber office (same as section 2) ☐ Other (if needed, provide shipping information below)

*Address _____ *City _____ *State _____ *ZIP _____

6. 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 certify that the requested additional nurse support is necessary beyond the support my office has already provided. 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 _____ OR _____ Date _____
Dispense as Written Substitution Allowed

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

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

4. UPTRAVI® Titration Education Program

- Check the box with the appropriate visit channel in this section if you would like your patient to receive Johnson & Johnson-sponsored education on administration, dosing, and titration of UPTRAVI®
- As the treating HCP, you or your patient can opt out at any time. To opt out, you can contact the Specialty Pharmacy directly

5. Shipping

- Check the appropriate box to indicate if the medicine should be shipped to the patient, your office, or another address. If Other, complete the fields below

IMPORTANT: The Specialty Pharmacy will call the phone number associated with the checkbox in this section to schedule the medicine shipment.

6. Prescriber Signature

- Ensure all ***(REQUIRED)** fields in Sections 1-5 are completed to ensure timely prescription fulfillment
- Remember to sign only once and fill in the Date

IMPORTANT: Signing above “Dispense as Written” indicates your preference for the patient to receive UPTRAVI® brand medicine.

Please remember to print clearly.

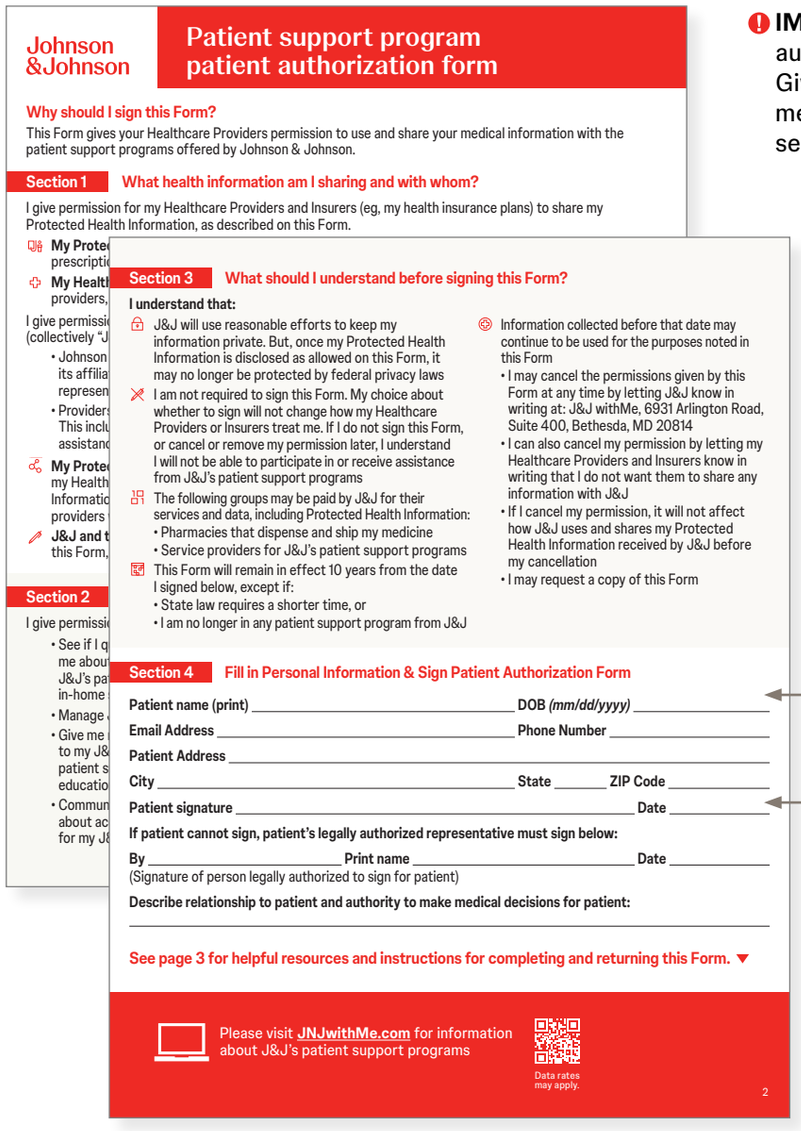
Please see full Prescribing Information and Patient Product Information for UPTRAVI®. Provide the Patient Product Information to your patients and encourage discussion.

Johnson & Johnson Patient Support Program Patient Authorization

Have your patient read, sign, and date the Patient Authorization

If your patient is not in the office, they can:

- Provide Patient Authorization electronically at **PAHconsent.com**
- Complete a Patient Authorization Form and fax it to 866-279-0669 or mail it to 6931 Arlington Road, Suite 400, Bethesda, MD 20814



Johnson &Johnson

Patient support program patient authorization form

Why should I sign this Form?

This Form gives your Healthcare Providers permission to use and share your medical information with the patient support programs offered by Johnson & Johnson.

Section 1 What health information am I sharing and with whom?

I give permission for my Healthcare Providers and Insurers (eg, my health insurance plans) to share my Protected Health Information, as described on this Form.

Section 2

Section 3 What should I understand before signing this Form?

I understand that:

- J&J will use reasonable efforts to keep my information private. But, once my Protected Health Information is disclosed as allowed on this Form, it may no longer be protected by federal privacy laws
- 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 in or receive assistance from J&J's patient support programs
- The following groups may be paid by J&J for their services and data, including Protected Health Information:
  - Pharmacies that dispense and ship my medicine
  - Service providers for J&J's patient support programs
- This Form will remain in effect 10 years from the date I signed below, except if:
  - State law requires a shorter time, or
  - I am no longer in any patient support program from J&J
- Information collected before that date may continue to be used for the purposes noted in this Form
- I may cancel the permissions given by this Form at any time by letting J&J know in writing at: J&J withMe, 6931 Arlington Road, Suite 400, Bethesda, MD 20814
- 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 J&J
- If I cancel my permission, it will not affect how J&J uses and shares my Protected Health Information received by J&J before my cancellation
- I may request a copy of this Form

Section 4 Fill in Personal Information & Sign Patient Authorization Form

Patient name (print) _____ **DOB** *(mm/dd/yyyy)* _____

Email Address _____ **Phone Number** _____

Patient Address _____

City _____ **State** _____ **ZIP Code** _____

Patient signature _____ **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:

_____

See page 3 for helpful resources and instructions for completing and returning this Form.

Please visit **JNJwithMe.com** for information about J&J's patient support programs

Data rates may apply.

2

- Please ask your patient to complete all fields, including their printed name
- By providing their email address, your patient agrees to receive support materials and resources via email

IMPORTANT: Patient signature **and** date are required for support and permissions outlined in the authorization.

IMPORTANT: Please ensure your patient understands that signing this form allows the patient to authorize the use and disclosure of their medical information for the purposes described in the form. Giving permission for doctors, health insurance companies, and pharmacies to share the patient's medical information with the Johnson & Johnson Patient Support Programs can help improve the services these programs provide the patient.

Helpful resources you can sign up for (optional)

Permission for communications outside of J&J's patient support programs:

☐ Yes, I would like to receive communications about my J&J medicine

☐ Yes, I would like to receive communications about other products and services from J&J

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 J&J's patient support programs or to receive any other communications I have selected. Cell phone number: _____

For privacy rights and choices specific to California, Colorado, Connecticut, Utah, Virginia, and Washington residents, please see J&J's US Supplemental Privacy Notice available at InnovativeMedicine.JNJ.com/us/privacy-policy#supplemental

How to Complete and Return the Patient Authorization Form

Sign and return pages 1 and 2 of this Form to: (If optional resources are selected, complete and return page 3)

Fax to: 866-279-0669

J&J withMe
6931 Arlington Road, Suite 400
Bethesda, MD 20814

Or, eSign a digital Form:

In your healthcare provider's office

At **PAHconsent.com** or scan this QR code

Data rates may apply.

3

- Your patient may find it helpful to receive additional resources from Johnson & Johnson:
  - Checking the first box authorizes J&J to send patient information and updates related to their prescribed J&J medicine
  - Checking the second box authorizes J&J to send communications relating to other products and services from J&J
- Your patient may call J&J withMe at any time with questions or to opt out of these communications
- Your patient has the option to check the box to opt in to receive text messages

The bottom of the form provides instructions for the two ways the patient may submit the completed authorization form: by filling out a printed form and sending to J&J withMe by fax or mail, or by completing the form online at **PAHconsent.com**.

Johnson&Johnson