

Enrollment and Prescription Form  
Fax Cover SheetFax 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](https://www.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](https://www.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](https://www.jnjwithme.com).

cp-142434v6

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 full [Prescribing Information](#) and [Patient Product Information](#) for UPTRAVI®. Provide the Patient Product Information to your patients and encourage discussion.**

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](#) further governs the use of the information you provide.

Fields marked with an (\*) are required.

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### 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

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

Best time to call \_\_\_\_\_

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

Dispense as Written

OR

Substitution Allowed

Date \_\_\_\_\_

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 full [Prescribing Information](#) and [Patient Product Information](#) for UPTRAVI®. Provide the Patient Product Information to your patients and encourage discussion.**

## 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.

 **My Protected Health Information includes information related to:** my medical condition, treatment, prescriptions, and health insurance coverage

 **My Healthcare Providers may include:** physicians, pharmacists, specialty pharmacies, other healthcare providers, and staff members at my healthcare providers' offices

I give permission to these people or groups to receive and use my Protected Health Information (collectively "J&J"):

- Johnson & Johnson Health Care Systems Inc., its affiliated companies, agents, and representatives
- Service providers for the patient support programs. This includes subcontractors or healthcare providers helping J&J run the programs
- Providers of other sources of funding. This includes foundations and co-pay assistance providers
- Service providers maintaining, transmitting, de-identifying, aggregating, or analyzing data from J&J's support programs

 **My Protected Health Information may be shared by J&J with these people and groups:** my Insurers, my Healthcare Providers, any other people given permission to receive and use my Protected Health Information (as mentioned above), anyone I give permission to as an additional contact, and service providers who review data from J&J's patient support programs

 **J&J and the other groups on this Form may share information about me in 2 ways:** as permitted on this Form, and if any information that identifies me is removed from what has been shared

## Section 2 How can giving permission help with patient support programs and access?

I give permission to J&J to receive, use, and share my Protected Health Information to:

- See if I qualify for, sign me up for, contact me about, and provide services relating to J&J's patient support programs. This includes in-home services
- Inform my Healthcare Provider that I am enrolled in J&J's patient support programs
- Manage J&J's patient support programs
- Help verify and coordinate coverage for J&J medicines with my Insurers and Healthcare Providers
- Give me resources and information related to my J&J medicine in connection with J&J's patient support programs. This includes educational and adherence materials
- Help with prescription or treatment location and associated scheduling
- Communicate with my Healthcare Providers about access, reimbursement, and fulfillment for my J&J medicine
- Conduct analysis to help J&J evaluate, create, and improve their patient support services and products for patients prescribed J&J medicines
- Share information from J&J's patient support programs that may be useful for my care

### 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](https://www.JNJwithMe.com) for information about J&J's patient support programs



Data rates may apply.



## 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](https://www.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](https://www.PAHconsent.com) or scan this QR code



Data rates may apply.