J&J withMe

Accredo Health Group Inc. Phone Number: 866-344-4874 **UEI: LERPSGUE3528**

FOR VA PATIENTS ONLY

UPTRAVI® (selexipag) Enrollment and Prescription Form

1. Forward this completed Enrollment and Prescription Form to the VA Pharmacy.
2. The VA Pharmacy will fax the completed form to J&J withMe at 866-279-0669.

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: _____ MI: _____ *Last name: _____ Sex at Birth: ☐ Female ☐ Male

*Birth date: _____ Primary language: _____ Email address: _____

*Primary phone #: _____ Alternate phone #: _____

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

Care Partner or legally authorized representative: _____ Relationship: _____ Phone #: _____

*2. UPTRAVI® Tablets Prescription Information

Please select the following titration dosing order or provide alternate dosing instructions 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

3. 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.

*4. Shipping

Ship to: ☐ Patient home ☐ VA pharmacy

VA pharmacy: _____

Address: _____

City: _____ State: _____ ZIP: _____

Payment Method:

☐ Credit Card (call pharmacy contact)

☐ E-Invoice Tungsten 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: _____

5. Prescriber Information (please print)

*Prescriber's full name: _____ State license #: _____

Site name: _____

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

*Main phone #: _____ Fax #: _____ NPI #: _____

*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 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®.

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

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Clear Form Print Form