



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®.



Please see full <u>Prescribing Information</u> and Patient Product Information for UPTRAVI®. Provide the <u>Patient Product Information</u> 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

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ate box. Keep in urer will make the
armacy will
y questions, contact CarePath at 866-228-
ugh Friday, 8:00 am to 8:00 pm

Please see full <u>Prescribing Information</u> and Patient Product Information for UPTRAVI®. Provide the <u>Patient Product Information</u> 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, Janssen CarePath will communicate with the patient in their chosen language whenever possible
- Checking one of the boxes to designate a caregiver or legally authorized representative to receive communications from Janssen CarePath 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, Janssen CarePath will need to reach out to the patient for this information, which can delay processing by 1 or more days

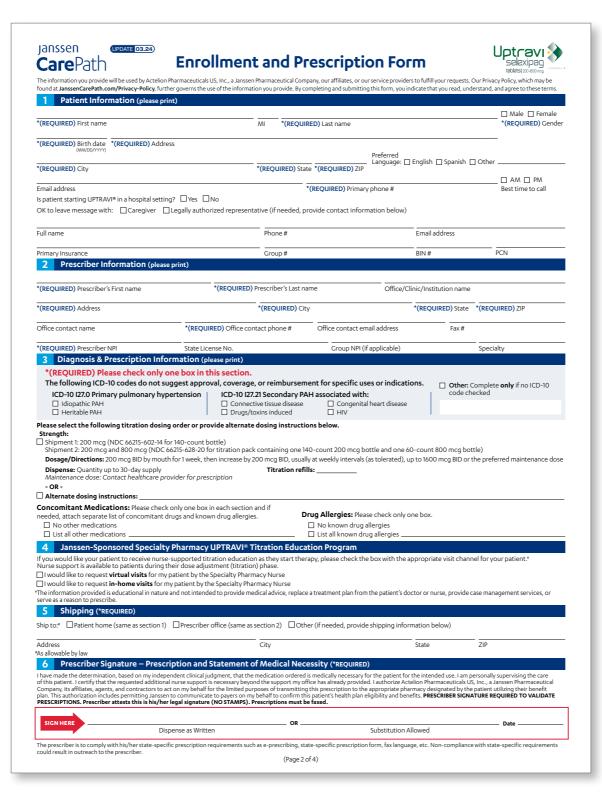
2 Prescriber Information

- 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
- If selecting "Alternate dosing instructions," please provide adequate instructions for the Specialty Pharmacy

If checking the box for "Concomitant Medications" 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.



Janssen-Sponsored Specialty Pharmacy UPTRAVI® Titration Education Program

- Check the box with the appropriate visit channel in this section if you would like your patient to receive Janssen-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 medication 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 medication 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 medication.

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

Janssen Patient Support Program Patient Authorization

Have your patient read, sign, and date the Patient Authorization in Section 7

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

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

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

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

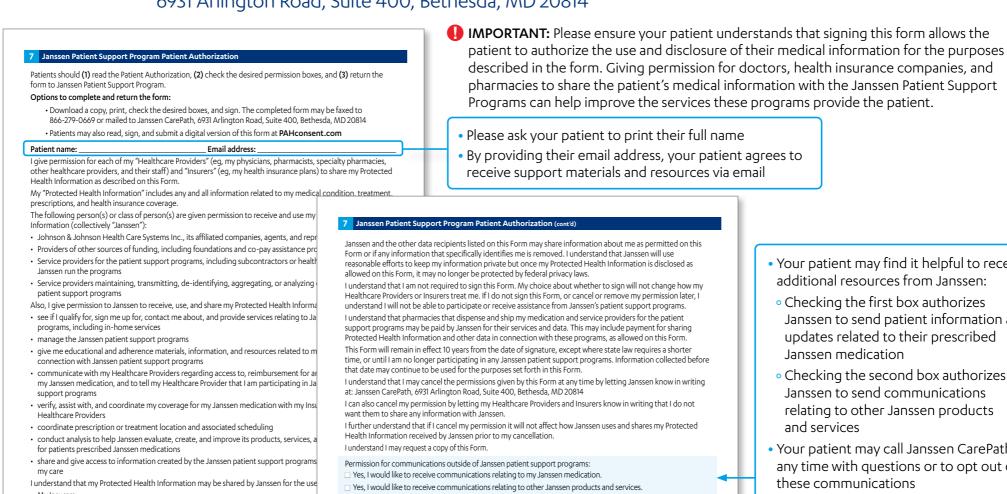
Describe relationship to patient and authority to make medical decisions for patient:

at https://www.janssen.com/us/privacy-policy#california

(Signature of person legally authorized to sign for patient)

Permission for text communications:

Cell phone number



- - Your patient may find it helpful to receive additional resources from Janssen: Checking the first box authorizes
 - Janssen to send patient information and updates related to their prescribed Janssen medication
 - Checking the second box authorizes Janssen to send communications relating to other Janssen products and services
 - Your patient may call Janssen CarePath 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
- **(1) IMPORTANT:** Patient signature **and** date are required for support and permissions outlined in the authorization.



My Healthcare Providers

Any of the persons given permission to receive and use my Protected Health Informat

Any individual I give permission as an additional contact