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

UPTRAVI® (selexipag) Enrollment and Prescription Form

FOR VA PATIENTS ONLY

1. Forward this completed form to the VA Pharmacy.
2. The VA Pharmacy will fax completed form to Accredo Health Group Inc. at 800-711-3526.
Fields marked with a (*) are required.

Actelion Pharmaceuticals US, 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.

1. Patient Information (please print)

*First name: _____ MI: _____ *Last name: _____ Gender: ☐ Female ☐ Male

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

*Primary phone #: _____ Alternate phone #: _____

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

Caregiver or legally authorized representative: _____ Relationship: _____ Phone #: _____

*2. UPTRAVI® Tablets Prescription Information

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

☐ **Strength:**

Shipment 1: 200 mcg (NDC 66215-602-14 for 140-count bottle)

Shipment 2: 200 mcg and 800 mcg (NDC 66215-628-20 for titration pack containing one 140-count 200 mcg bottle and one 60-count 800 mcg bottle)

Dosage/Directions: 200 mcg BID by mouth for 1 week, then increase by 200 mcg BID, usually at weekly intervals (as tolerated), up to 1600 mcg BID or the preferred maintenance dose

Dispense: Quantity up to 30-day supply

Titration refills:_____

Maintenance dose: Contact healthcare provider for prescription

- OR -

☐ **Alternate dosing instructions:**

3. Janssen-Sponsored Specialty Pharmacy UPTRAVI® Titration Education Program

If you would like your patient to receive nurse-supported patient education on administration, dosing, and titration of UPTRAVI® and/or their disease, 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 **virtual visits** for my patient by the Specialty Pharmacy Nurse

☐ I would like to request **in-home 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. Physician Information (please print)

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

Site name: _____

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

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

*6. Physician Signature

I have made the determination, based on my independent clinical judgment, that the medication ordered is medically necessary for the patient for the intended use. I am personally supervising the care of this patient. I authorize Actelion Pharmaceuticals US, Inc., a Janssen Pharmaceutical Company, 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. I certify that the requested additional titration support is necessary beyond the support my office has already provided. I also certify that the patient has authorized me to share their information on this form. **PHYSICIAN SIGNATURE REQUIRED TO VALIDATE PRESCRIPTIONS. Physician attests this is his/her legal signature (NO STAMPS). Prescriptions must be faxed.**

Physician signature _____ Dispense as Written

Physician signature _____ Substitution Allowed **Date** _____

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

Clear Form Print Form

janssen PHARMACEUTICAL COMPANIES OF Johnson & Johnson