

Once you've completed this form, please see below for documentation requirements for ALL patients: Patients to complete and sign section 6 (pages 2 and 3) or submit a digital version of the Janssen Patient Support Program Patient Authorization at PAHconsent.com.



[Female patients only]

Must complete the OPSUMIT® REMS Patient Enrollment and Consent Form.*

*Please visit OPSUMITREMS.com to download the form.



Fax the following forms to Janssen CarePath at 866-279-0669:

- 1) [ALL patients] This OPSUMIT® PSMN Form
- 2) [Female patients only] OPSUMIT® REMS Patient Enrollment and Consent Form
- 3) Please provide copies of all medical and prescription insurance cards (front and back)

Requirements to expedite OPSUMIT® Voucher Program shipping (see section 4):

- 1) Complete all **★REQUIRED** fields in this form
- 2) Fax this form, along with the REMS form [female patients only], to Janssen CarePath before 1:00 PM, Eastern time
If requirements above are met, and forms are received Mon–Fri, OPSUMIT® may ship as soon as the same business day.

The information you provide will be used by Actelion Pharmaceuticals US, Inc., a Janssen Pharmaceutical Company, our affiliates, or our service providers to fulfill your requests. Our [Privacy Policy](#) further governs the use of the information you provide. By completing and submitting this form, you indicate that you read, understand, and agree to these terms.

1 Patient Information (please print)

| | | | | | |
|--|--|---|-------------------------|--|---|
| ★ (REQUIRED) First name _____ MI _____ | | ★ (REQUIRED) Last name _____ | | ★ (REQUIRED) Birth date (MM/DD/YYYY) _____ | ★ (REQUIRED) Gender _____ <input type="checkbox"/> Male <input type="checkbox"/> Female |
| ★ (REQUIRED) Address _____ | | | ★ (REQUIRED) City _____ | | ★ (REQUIRED) State _____ |
| ★ (REQUIRED) Primary phone # _____ | | Cell phone # or <input type="checkbox"/> check if same as primary _____ | Best time to call _____ | Specialty pharmacy preference _____ | ★ (REQUIRED) ZIP _____ <input type="checkbox"/> English <input type="checkbox"/> Spanish Preferred Language |
| Email address _____ | | Legally authorized representative name _____ | | Phone # _____ | |

2 Prescriber Information (please print)

| | | | | | |
|------------------------------------|--|------------------------------------|--|------------------------------|--|
| ★ (REQUIRED) First name _____ | | ★ (REQUIRED) Last name _____ | | | |
| ★ (REQUIRED) Prescriber NPI _____ | | Site name _____ | | Specialty _____ | |
| ★ (REQUIRED) Address _____ | | ★ (REQUIRED) City _____ | | ★ (REQUIRED) State _____ | |
| ★ (REQUIRED) ZIP _____ | | Office contact name _____ | | Office contact phone # _____ | |
| Office contact email address _____ | | Office contact email address _____ | | Fax # _____ | |

3 Diagnosis & Prescription Information (please print)

★ (REQUIRED) The following ICD-10 codes do not suggest approval, coverage, or reimbursement for specific uses or indications. (Please check only one box below.)

- | | | |
|--|---|---|
| <input type="checkbox"/> ICD-10 I27.0 Primary pulmonary hypertension | <input type="checkbox"/> ICD-10 I27.21 Secondary PAH associated with: | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Idiopathic PAH | <input type="checkbox"/> Connective tissue disease | <input type="checkbox"/> Congenital heart disease |
| <input type="checkbox"/> Heritable PAH | <input type="checkbox"/> Drugs/toxins induced | <input type="checkbox"/> HIV |

OPSUMIT® (macitentan) 10 mg tablet(s) _____
NDC 66215-501-30

★ (REQUIRED) Time(s) daily _____ ★ (REQUIRED) Quantity _____ ★ (REQUIRED) Refills _____ ★ (REQUIRED) Instructions for use _____

4 OPSUMIT® Voucher Program

| | | | | | | | | | | | |
|---|---|------------|-------------------------------|---------------|--|------------|-------------|-----------|---------------|--|--|
| <input type="checkbox"/> Dispense OPSUMIT® Voucher Program The OPSUMIT® Voucher Program is a 30-day supply of OPSUMIT® free of charge for eligible patients. Dose: 10 mg tablet once daily Dispense: 1-month supply Refills: 0 Dispensing pharmacy may contact you for additional information | <p>★ (REQUIRED Only if "Dispense OPSUMIT® Voucher Program" is selected)</p> <p>Ship to: <input type="checkbox"/> Patient home (same as above) <input type="checkbox"/> Prescriber office (same as above) <input type="checkbox"/> Other _____ Preferred day/time _____</p> <table border="1" style="width:100%"> <tr> <td>Name _____</td> <td>Company (if applicable) _____</td> </tr> <tr> <td colspan="2">Address _____</td> </tr> <tr> <td>City _____</td> <td>State _____</td> <td>ZIP _____</td> <td>Phone # _____</td> </tr> </table> <table border="0" style="width:100%"> <tr> <td style="width:50%"> Concomitant Medications ★ (REQUIRED) Please check only one box below. <input type="checkbox"/> No other medications <input type="checkbox"/> List all other medications below Other medications (including herbal supplements) _____ </td> <td style="width:50%"> Drug Allergies ★ (REQUIRED) Please check only one box below. <input type="checkbox"/> No known drug allergies <input type="checkbox"/> List all known drug allergies below All known allergies _____ </td> </tr> </table> | Name _____ | Company (if applicable) _____ | Address _____ | | City _____ | State _____ | ZIP _____ | Phone # _____ | Concomitant Medications ★ (REQUIRED) Please check only one box below. <input type="checkbox"/> No other medications <input type="checkbox"/> List all other medications below Other medications (including herbal supplements) _____ | Drug Allergies ★ (REQUIRED) Please check only one box below. <input type="checkbox"/> No known drug allergies <input type="checkbox"/> List all known drug allergies below All known allergies _____ |
| Name _____ | Company (if applicable) _____ | | | | | | | | | | |
| Address _____ | | | | | | | | | | | |
| City _____ | State _____ | ZIP _____ | Phone # _____ | | | | | | | | |
| Concomitant Medications ★ (REQUIRED) Please check only one box below. <input type="checkbox"/> No other medications <input type="checkbox"/> List all other medications below Other medications (including herbal supplements) _____ | Drug Allergies ★ (REQUIRED) Please check only one box below. <input type="checkbox"/> No known drug allergies <input type="checkbox"/> List all known drug allergies below All known allergies _____ | | | | | | | | | | |

5 Statement of Medical Necessity

★ (REQUIRED) 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. This authorization includes permitting Janssen 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.**

Prescriber signature _____ Dispense as Written _____ Prescriber signature _____ Substitution Allowed _____ Date _____

Please see the full [Prescribing Information](#), including Boxed Warning for embryo-fetal toxicity, and [Medication Guide](#) for OPSUMIT®. Provide the Medication Guide to your patients and encourage discussion.

6 Janssen Patient Support Program Patient Authorization

Patients should **(1)** read the Patient Authorization, **(2)** check the desired permission boxes, and **(3)** return the form to Janssen Patient Support Program.

Options to complete and return the form:

- A. Download a copy, print, check the desired boxes, and sign. The completed form may be faxed to 866-279-0669 or mailed to Janssen CarePath, PO Box 826, South San Francisco, CA 94083.
- B. Patients may also read, sign, and submit a digital version of this form at [PAHconsent.com](https://www.janssen.com/PAHconsent).

Patient name: _____

Email address: _____

I give permission for each of my “Healthcare Providers” (eg, my physicians, pharmacists, specialty pharmacies, other healthcare providers and their staff) and “Insurers” (eg, my health insurance plans) to share my Protected Health Information.

My “Protected Health Information” includes but is not limited to the following information related to my medical condition, treatment, prescriptions, and health insurance coverage.

The following person(s) or class of person(s) are given permission to receive and use my Protected Health Information (collectively “Janssen”):

- Johnson & Johnson Health Care Systems Inc., its affiliated companies, agents, and representatives
- Providers of other sources of funding include foundations and co-pay assistance providers
- Service providers supporting or analyzing data from Janssen patient support programs

Specifically, I give permission to Janssen to receive, use, and share my Protected Health Information in order to:

- see if I qualify for, sign me up for, and contact me about Janssen patient support programs
- manage the Janssen patient support programs
- give me educational and adherence materials, information, and resources related to my Janssen medication in connection with Janssen patient support programs
- communicate with my Healthcare Providers regarding access to, reimbursement for and fulfillment of my Janssen medication, and to confirm to my Healthcare Provider that support has been provided by the Janssen patient support programs
- verify, assist with, and coordinate my coverage for my Janssen medication with my Insurers and Healthcare Providers
- coordinate prescription or treatment location and associated scheduling
- conduct analysis to help Janssen evaluate, create and improve its products, services, and customer support for patients prescribed Janssen medications
- share and give access to information created by the Janssen patient support programs that may be useful for my care

I understand that my Protected Health Information may be shared by Janssen for the uses written in this Form to:

- My Insurers
- My Healthcare Providers
- Any of the persons given permission to receive and use my Protected Health Information as mentioned above
- Any individual I give permission as an additional contact

6 Janssen Patient Support Program Patient Authorization (cont'd)

I understand that my Protected Health Information will not be used or shared by Janssen for any other use without my permission. Janssen may share information about me where legally allowed or if any information that specifically identifies me is removed. I understand that Janssen will make every effort to keep my information private. Further, I understand that if my information is accidentally shared, federal privacy laws do not require that the person/party receiving it not share the information further and that such information provided to a third party may no longer be protected by federal privacy laws. I understand that my pharmacy may receive compensation in connection with sharing my information with Janssen as allowed under this Authorization.

I understand that 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 or receive assistance from Janssen's patient support programs.

This Form will remain in effect 10 years from the date of signature, except where state law requires a shorter time, or until I am no longer participating in any Janssen patient support programs. Information collected before that date may continue to be used for the purposes set forth in this Form.

I understand that I may cancel the permissions given by this Form at any time by letting Janssen know in writing at: Janssen CarePath, PO Box 826, South San Francisco, CA 94083

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 Janssen.

I further understand that if I cancel my permission it will not affect how Janssen uses and shares my Protected Health Information received by Janssen prior to my cancellation.

I understand I may request a copy of this Form.

Permission for communications outside of Janssen patient support programs:

- Yes, I would like to receive communications relating to my Janssen medication.
- Yes, I would like to receive communications relating to other Janssen products and services.

For privacy rights and choices specific to California residents, please see Janssen's California [privacy notice](#)

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 the Janssen patient support programs or to receive any other communications I have selected.

Cell phone number: _____

Patient sign here: _____ **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:
