Janssen CarePath

Ponvory™ (ponesimod) tablets

Attestation Form

Completion of Pretests and Assessments

Before initiation of treatment with PONVORY™, assess the following based on individual patient needs: Complete Blood Count, Cardiac Evaluation, Liver Function Tests, Ophthalmic Evaluation, Current or Prior Medications with Immune System Effects, and Vaccinations.

Instructions for Prescriber and/or a representative authorized by the Prescriber to sign and act on their behalf ("Authorized Representative")

1. Please read and sign the attestation below with healthcare provider or authorized representative signature

2. Fax the completed form to 833-200-6306

If the form is not submitted, Janssen CarePath will call you and/or your office for verbal confirmation of completion of pretests and assessments.

Patient Information

Patient Name (First, MI, Last) ______ Date of Birth (mm/dd/yyyy) ______

By signing this form, I attest that I have assessed the following based on individual patient needs: Complete Blood Count, Cardiac Evaluation, Liver Function Tests, Ophthalmic Evaluation, Current or Prior Medications with Immune System Effects, and Vaccinations. This patient is cleared to initiate therapy with PONVORY™.

Please complete and sign Prescriber Information OR Authorized Representative Information:

Prescriber Information

Prescriber Name (Please print) ______ Prescriber NPI ______ Site Phone ______

Site Name and Address ______ City ______ State ______ ZIP ______

Prescriber Signature (NO STAMPS ALLOWED) ______ Date (mm/dd/yyyy) ______

OR

Authorized Representative Information

Authorized Representative Name (Please print) ______ Authorized Representative Title ______

Prescriber Name (Please print) ______ Prescriber NPI ______ Site Phone ______

Site Name and Address ______ City ______ State ______ ZIP ______

Authorized Representative Signature (NO STAMPS ALLOWED) ______ Date (mm/dd/yyyy) ______

First dose monitoring is (please check one):

☐ **Required.** I confirm I have counseled my patient on first dose monitoring requirements as described in the Prescribing Information. Please ship to the address below.

☐ **Not Required.** Janssen CarePath will ship to the site or patient address you provided previously on the Prescription Enrollment Form. If that address is no longer valid, please provide an updated site or patient address below and Janssen CarePath will ship to this address instead.

Ship to address:

Site Name (or Patient Name) ______ Site Contact (if applicable) ______ Phone ______

Address ______ City ______ State ______ ZIP ______

Please see full Prescribing Information and Medication Guide for PONVORY™.
Provide the Medication Guide to your patients and encourage discussion.

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