UPTRAVI® (selexipag) Prescription and Patient Enrollment Form

FAX COVER SHEET

Date: _____

To: ACTELION Pathways Fax number: **1-866-279-0669**

From: _____

Facility name: _____

Facility contact: _____

Completed UPTRAVI Prescription and Patient Enrollment Form enclosed.

Number of pages (including cover): _____

Specialty pharmacy preference: ☐ Accredo ☐ CVS/specialty

Comments: _____

_____

_____

_____

Contact *Actelion Pathways*® at 1-866-ACTELION (1-866-228-3546).

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UPTRAVI® (selexipag) Prescription and Patient Enrollment Form

EU2201803

- **Complete this form for all patients. Fields marked with a (*) are required**
- **Fax completed form and copy of patient's insurance card to 1-866-279-0669 and/or include copy of patient demo from electronic medical records**

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: _____

Legal guardian: _____ Relationship: _____ Phone #: _____

Is patient starting UPTRAVI in a hospital setting? ◯ Yes ◯ No

*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)

Post-titration (highest tolerated) dose: Contact healthcare provider for prescription

Dosage/Directions: 200 mcg BID by mouth for 1 week, then increase by 200 mcg BID, at weekly intervals, to the highest tolerated dose up to 1600 mcg BID

Dispense: Quantity sufficient for up to maximum allowable dose for up to a 30-day supply

Titration refills: _____

- OR -

☐ **Alternate dosing instructions:**

3. Shipping

Ship to: ☐ Patient home ☐ Prescriber office ☐ Other

Other Address: _____

City: _____ State: _____ ZIP: _____

*4. Titration Support

Please select from the following specialty pharmacy titration support services and provide any special instructions, if applicable.

1. Specialty pharmacy to provide home visit from nurse for patient education related to UPTRAVI dosing and titration.
   ◯ Yes ◯ No
   If yes, indicate number and frequency of visits _____
2. Specialty pharmacy clinician to assess patient with each dose change via telephone until the highest tolerated dose is achieved.
   ◯ Yes ◯ No

Special instructions (optional):

5. Physician Information (*please print*)

*Physician's full name: _____

Site name: _____

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

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

MD state license number: _____

*6. Physician Signature: Prescription and Statement of Medical Necessity

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., its affiliates, agents, and contractors (collectively, "Actelion") 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 Actelion to communicate to payers on my behalf to confirm this patient's health plan eligibility and benefits. **PHYSICIAN SIGNATURE REQUIRED TO VALIDATE PRESCRIPTIONS. Physician attests this is his/her legal signature (NO STAMPS). Prescriptions must be faxed.**

Physician's signature (dispense as written): _____ Date: _____

Physician's signature (substitution allowed): _____ Date: _____

The physician is to comply with their state-specific prescription requirements, such as e-prescribing, state-specific prescription form, fax language, etc. Noncompliance with state-specific requirements could result in outreach to the prescriber.

*7. Diagnosis

The following ICD-9/ICD-10 codes do not suggest approval, coverage, or reimbursement for specific uses or indications. (Check the box for the appropriate code below.)

☐ **ICD-9 416.0/ICD-10 I27.0 Primary pulmonary hypertension**

☐ **ICD-9 416.8/ICD-10 I27.21 Secondary pulmonary arterial hypertension**

☐ **Other** _____

*8. *Actelion Pathways*® Services Authorization

By signing this Authorization, I agree that I want *Actelion Pathways*® support, including prescription/enrollment assistance and evaluation for financial assistance, and authorize *Actelion Pathways*® to use and/or share my information ("Authorization").

I authorize my healthcare providers, pharmacies, health plans or payers ("my health care organizations") to share personal and health information about me related to my Actelion PAH therapies ("my information") with Actelion Pharmaceuticals US, Inc., its affiliates, agents and contractors (collectively, "Actelion"). I understand that once my information is shared with Actelion, my information may be protected by certain state privacy laws but not by federal health privacy laws, and may be redisclosed by Actelion. Actelion agrees to protect my information and to use and share it only for the reasons listed below. I understand that my pharmacy may receive compensation in connection with sharing my information with Actelion as allowed under this Authorization.

I authorize my health care organizations to share my information with Actelion, in order for Actelion to: (1) contact me or my healthcare organizations, or others I have identified, about my disease or treatment; (2) confirm my health plan eligibility and benefits, identify other payers for my therapy, or determine whether I may be eligible for assistance programs; (3) enroll me in Actelion PAH therapies-related programs and provide therapy access support services; (4) perform analyses or improve or develop products, services, programs, or treatment, related to my disease; (5) provide me by any means of communication, including by e-mail, mail, or telephone (including voicemail), with information to educate or inform me about Actelion PAH therapies and ways to help me maintain my prescribed treatment; and (6) use and disclose my information for safety reasons or as required by law. I understand that if I do not sign this form, I will still be eligible for health plan benefits and my treatment and payment for my treatment by my healthcare providers and pharmacy will not be affected, but I will not have access to the Actelion services and support described above.

This Authorization will expire 10 years from the date signed below unless a shorter period is required by the law of my state of residence. I may discuss the scope of my Authorization at any time by calling 1-866-875-0277 and may cancel it by writing a letter saying I cancel my Authorization, and mailing it to Actelion Pharmaceuticals US, Inc.: PO Box 826, South San Francisco, CA 94083. My cancellation will not be effective until after Actelion receives it and my health care organizations are notified of it by Actelion, and it will not apply to prior actions taken by Actelion and my health care organizations based on this Authorization. I have a right to request and receive a copy of this Authorization in the same ways described above for cancellation.

*Patient name (print): _____

*Patient or parent/guardian/representative signature: _____ *Date: _____

If this form is signed by someone who is not the patient listed, describe the signer's legal authority to act for the patient:

_____

☐ **No, I do not authorize *Actelion Pathways*® to use and/or share my information ("Authorization").**

Please note: In order to receive prescription/enrollment assistance, evaluations for financial assistance, and support services, patient must agree to share their information with *Actelion Pathways*®. By checking "No" above, patient will not receive these services.

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