INSTRUCTIONS FOR ENROLLMENT

Patient Assistance Program (PAP) Application

Johnson & Johnson PATIENT ASSISTANCE FOUNDATION, INC.

PATIENT CHECKLIST FOR SUBMITTING AN APPLICATION

- ☐ Read the Patient Declaration and Patient Authorization to Share Health Information on page 8, then complete all relevant patient information on page 2, and **sign and date** as required
- ☐ Include a copy of the **front and back** of your insurance card
- ☐ **Proof of income** (Choose one): Check the box in Section 4 on page 2 **OR** Include a copy of your most recent 1040 or 1040-SR Federal tax return
- ☐ Ask your Healthcare Professional (HCP) to complete their sections of this application, and sign and date in the "HCP Authorization" section(s) for the product(s) they have prescribed
- ☐ Submit completed page 2 and the pages your HCP has completed for your prescribed product(s) with documentation to:

Mail: Johnson & Johnson Patient Assistance Foundation, Inc., 610 Crescent Executive Court, Suite 200, Lake Mary, FL 32746

Fax: 833-919-3509 (toll free) / 240-575-3932 (direct dial)

Missing information and/or required documents may delay processing of application.

If you have questions about Johnson & Johnson Patient Assistance Foundation, Inc. (JJPAF) or how to complete this form, please contact us at 833-919-3510 (toll free) / 308-920-4358 (direct dial), 9am – 6pm EST, Monday through Friday.

PULMONARY ARTERIAL HYPERTENSION (PAH) MEDICATIONS AVAILABLE THROUGH THE PAP

Opsumit® macitentan tablets 10 mg

Ventavis® (iloprost) INHALATION SOLUTION

Tracleer® BOSENTAN

VELETRI® epoprostenol for Injection

Uptravi® selexipag tablets | 200-1600 mcg

The Johnson & Johnson Patient Assistance Foundation, Inc. (JJPAF) is an independent, non-profit organization that is committed to helping eligible patients without insurance coverage receive prescription products donated by Johnson & Johnson operating companies.

You may be eligible for our free prescription program for up to one year if you meet the requirements below:

- You have been prescribed a Johnson & Johnson operating company donated medication
- You meet the eligibility income requirements for the medication(s)
- You don't have insurance or medicine is not covered
  - — Some patients with Medicare Prescription Drug Coverage (Part D) who cannot afford their medicines and who meet certain financial criteria may also be eligible for assistance.
- You live in the United States or a U.S. territory
- You are being treated by a U.S. licensed doctor as an outpatient

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Patient Assistance Program Application

Johnson & Johnson PATIENT ASSISTANCE FOUNDATION, INC.

TO BE COMPLETED BY THE PATIENT See checklist on page 1—all information is required.

1 Patient Information

First Name: _____ Last Name: _____ Email: _____

Preferred Phone: _____ Phone Type: ☐ Home ☐ Mobile OK to leave message? ☐ Yes ☐ No

Social Security #: _____ Date of Birth: _____ Gender: ☐ Male ☐ Female

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

2 Financial Information

Federal Taxes *(Select one of the options below **ONLY** if you do not check the box in Section 4)*

☐ A copy of my most recent 1040 or 1040-SR Federal tax return is attached.

☐ I do not file Federal taxes.

(Tax returns may be reviewed and additional documentation requested.)

Total Gross Yearly Income *(required)*

Entire household: $ _____

Household Size *(required)*

Including yourself, the number of people who live in your home and are dependent on your household income: _____

3 Healthcare Insurance Information (Select all that apply.)

Please provide copies of front and back of all medical and prescription insurance cards.

Subscriber Name: _____ Date of Birth: _____ Relationship to Patient: _____

Primary Plan Name: _____ Secondary Plan Name: _____

☐ Check if no insurance	ID/Policy #	Group #	Phone
☐ Prescription Insurance/Medicare Part D Plan Plan Name: _____ Fax: _____ Rx BIN #: _____ Rx PCN: _____			
☐ Private/Commercial Insurance			
☐ Medicaid			
☐ Medicare Part B			
☐ Medicare Advantage			
☐ Veterans Administration			
☐ ADAP AIDS			
☐ SPAP State Patient Assistance Program			
☐ Other:			

4 Patient Declaration/Authorization to Assign Representative for Program Enrollment

Signature and date required before submission.

My signature below indicates that I have read, understand, and agree to the Patient Declaration and Patient Authorization to Share Health Information on page 8. If I have listed an authorized representative below, I permit the Johnson & Johnson Patient Assistance Foundation, Inc. (JJPAF) to discuss my application with this person. This includes the status of my application, insurance and financial questions, any missing documentation, and other issues related to my application and participation, throughout my enrollment period in the program. By signing below, this representative is allowed to speak on my behalf regarding my application with JJPAF.

CHECK THE BOX: ☐

Applicant Financial Verification Authorization

I also understand that JJPAF and the vendors associated with administrating the Program (collectively the "Program Administrators") may obtain a credit report or investigative credit report about me which may contain information as to my income or credit standing, to determine my eligibility for the Program. I hereby authorize such credit report and income verification and acknowledge that such authorization extends to consumer reporting agencies and to subsequent reports for purposes of determining my eligibility for the JJPAF Program.

PLEASE COMPLETE, SIGN & DATE:

Patient Name *(print)*: _____ Date: _____

Authorized Representative Name *(print if applicable)*: _____

Relationship to Patient *(print if applicable)*: _____ Phone: _____

_____ Date: _____

Patient Signature/Authorized Representative

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Patient Assistance Program Application

Johnson & Johnson PATIENT ASSISTANCE FOUNDATION, INC.

TO BE COMPLETED BY THE HEALTHCARE PROFESSIONAL (HCP)—all information is required for product(s) selected.

1 OPSUMIT®* (macitentan) Tablets

Patient Name: _____ Date of Birth: _____

HCP INFORMATION

Name: _____ Site Name: _____

Site Contact: _____ Business Hours: _____

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

Phone: _____ Fax: _____ Email: _____

Tax ID #: _____ NPI # *(required)*: _____ State License # *(required)*: _____ Expiration *(mm/yyyy)*: _____

Collaborating MD *(for mid-level providers)*: _____ Collaborating MD NPI # *(required)*: _____

PRESCRIPTION INFORMATION FOR OPSUMIT® TABLETS

ICD-10 Code *(required)*: _____

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

Time(s) daily *(required)*: _____ Quantity *(required)*: _____ Refills *(required)*: _____ Instructions for use *(required)*: _____

SHIP TO

☐ Patient home ☐ Prescriber office ☐ Other—Please specify address if different from patient home or prescriber office.

Other Address (no PO box): _____

City: _____ State: _____ ZIP: _____

Ship Attn: _____

HCP AUTHORIZATION

My signature below indicates that I have read, understand, and agree to the Johnson & Johnson Patient Assistance Foundation, Inc. policy and the terms of Program participation on page 9.

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute	May Substitute / Product Selection Permitted / Submission Permissible
▶ _____	▶ _____
Prescriber's Signature Date	Prescriber's Signature Date

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words **"No Substitution":** _____

The prescriber 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.

***Please read full Prescribing Information, including Boxed Warning.**

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Patient Assistance Program Application

Johnson & Johnson PATIENT ASSISTANCE FOUNDATION, INC.

TO BE COMPLETED BY THE HEALTHCARE PROFESSIONAL (HCP)—all information is required for product(s) selected.

2 TRACLEER®* (bosentan) Tablets

Patient Name: _____ Date of Birth: _____

HCP INFORMATION

Name: _____ Site Name: _____

Site Contact: _____ Business Hours: _____

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

Phone: _____ Fax: _____ Email: _____

Tax ID #: _____ NPI # *(required)*: _____ State License # *(required)*: _____ Expiration *(mm/yyyy)*: _____

Collaborating MD *(for mid-level providers)*: _____ Collaborating MD NPI # *(required)*: _____

PRESCRIPTION INFORMATION FOR TRACLEER® TABLETS

ICD-10 Code *(required)*: _____

TRACLEER® Pediatric Dosing: 32 mg tablets (NDC 66215-103-56)
Directions for use and dispensing instructions: Complete the fields below

Sig: _____ Dose: _____ (mg per dose) Disp: _____ day supply Refill x _____

SHIP TO

☐ Patient home ☐ Prescriber office ☐ Other—Please specify address if different from patient home or prescriber office.

Other Address (no PO box): _____

City: _____ State: _____ ZIP: _____

Ship Attn: _____

HCP AUTHORIZATION

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Prescriber's Signature Date	Prescriber's Signature Date

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The prescriber 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.

***Please read full Prescribing Information, including Boxed Warning.**

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Patient Assistance Program Application

Johnson & Johnson PATIENT ASSISTANCE FOUNDATION, INC.

TO BE COMPLETED BY THE HEALTHCARE PROFESSIONAL (HCP)—all information is required for product(s) selected.

3 UPTRAVI® (selexipag) Tablets

Patient Name: _____ Date of Birth: _____

HCP INFORMATION

Name: _____ Site Name: _____

Site Contact: _____ Business Hours: _____

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

Phone: _____ Fax: _____ Email: _____

Tax ID #: _____ NPI # *(required)*: _____ State License # *(required)*: _____ Expiration *(mm/yyyy)*: _____

Collaborating MD *(for mid-level providers)*: _____ Collaborating MD NPI # *(required)*: _____

PRESCRIPTION INFORMATION FOR UPTRAVI® TABLETS

ICD-10 Code *(required)*: _____

Please select the following titration dosing order or provide alternate dosing instructions below. *(required)*

☐ **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)

OR

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

☐ **Alternate dosing instructions:** _____

SHIP TO

☐ Patient home ☐ Prescriber office ☐ Other—Please specify address if different from patient home or prescriber office.

Other Address (no PO box): _____

City: _____ State: _____ ZIP: _____

Ship Attn: _____

NURSE SUPPORT*

☐ Please check this box if you would like your patient to receive nurse-supported* patient education on administration, dosing and titration of UPTRAVI® and/or their disease. Nurse support* is available to patients during their dose adjustment (titration) phase.

**Nurse support is limited to education for patients about their therapy, its administration, and/or their disease. It is intended to supplement a patient's understanding of their therapy, and is not intended to provide medical advice, replace a treatment plan from the patient's doctor or nurse, directly provide case management services, or serve as a reason to prescribe. Program rules and limitations will apply.*

HCP AUTHORIZATION

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Prescriber's Signature Date	Prescriber's Signature Date

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words **"No Substitution":** _____

The prescriber 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.

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Patient Assistance Program Application

Johnson & Johnson PATIENT ASSISTANCE FOUNDATION, INC.

TO BE COMPLETED BY THE HEALTHCARE PROFESSIONAL (HCP)—all information is required for product(s) selected.

4 VELETRI® (epoprostenol) for Injection—continuous IV infusion administered via ambulatory pump

Patient Name: _____ Date of Birth: _____

HCP INFORMATION

Name: _____ Site Name: _____

Site Contact: _____ Business Hours: _____

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

Phone: _____ Fax: _____ Email: _____

Tax ID #: _____ NPI # *(required)*: _____ State License # *(required)*: _____ Expiration *(mm/yyyy)*: _____

Collaborating MD *(for mid-level providers)*: _____ Collaborating MD NPI # *(required)*: _____

Provider Transaction Access Number (PTAN) *(required if the patient has Medicare)*: _____

PRESCRIPTION INFORMATION FOR VELETRI® FOR INJECTION

ICD-10 Code *(required)*: _____ Dosing weight: _____ ☐ lbs ☐ kg Height: _____ ☐ in ☐ cm

☐ NKDA ☐ Known drug allergies: _____

Diabetic: ☐ Yes ☐ No Initial dose: _____ ng per kg per min

Titrate by _____ ng per kg per min every _____ days until goal of _____ ng per kg per min is reached.

Discharge dose: _____ ng per kg per min Concentration: _____ ng/mL

Dispense two (2) ambulatory infusion pumps appropriate for VELETRI® if the patient does not currently have appropriate ambulatory infusion pumps.

Refills: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11

Patients should keep at least a 7-day backup supply of medication and supplies at all times.

Quantity: Dispense 1 month of drug and supplies, including pump(s)

Diluent for VELETRI® – Choose One: ☐ Sterile water for injection ☐ Sodium chloride 0.9% injection

SHIP TO

☐ Patient home ☐ Prescriber office ☐ Other—Please specify address if different from patient home or prescriber office.

Other Address (no PO box): _____

City: _____ State: _____ ZIP: _____

Ship Attn: _____

NURSE SUPPORT

Choose one: ☐ Urgent: Patient in hospital ☐ Emergent: Admission after 48-72 hours ☐ Standard: Admission within 4+ days

Start-of-care date *(required)*: _____ Tentative discharge date: _____

Nursing services requested to be provided by the specialty pharmacy staff (Check all that apply):

☐ In-hospital training ☐ Postdischarge visit/in-home follow-up ☐ Home assessment/training prior to initiation of therapy

☐ Dispense teaching kits ☐ DECLINE: All referenced nursing

If nursing services will be required for therapy administration, the home health nurse will call for additional orders per state regulations.

Discharge planner/coordinator name: _____

Date: _____ Time: _____ Fax #: _____ Office/page phone #: _____

HCP AUTHORIZATION

My signature below indicates that I have read, understand, and agree to the Johnson & Johnson Patient Assistance Foundation, Inc. policy and the terms of Program participation on page 9.

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute	May Substitute / Product Selection Permitted / Submission Permissible
▶ _____	▶ _____
Prescriber's Signature Date	Prescriber's Signature Date

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words **"No Substitution":** _____

The prescriber 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.

Print Form

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Patient Assistance Program Application

Johnson & Johnson PATIENT ASSISTANCE FOUNDATION, INC.

TO BE COMPLETED BY THE HEALTHCARE PROFESSIONAL (HCP)—all information is required for product(s) selected.

5 VENTAVIS® (iloprost) Inhalation Solution

Patient Name: _____ Date of Birth: _____

HCP INFORMATION

Name: _____ Site Name: _____

Site Contact: _____ Business Hours: _____

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

Phone: _____ Fax: _____ Email: _____

Tax ID #: _____ NPI # *(required)*: _____ State License # *(required)*: _____ Expiration *(mm/yyyy)*: _____

Collaborating MD *(for mid-level providers)*: _____ Collaborating MD NPI # *(required)*: _____

Provider Transaction Access Number (PTAN) *(required if the patient has Medicare)*: _____

PRESCRIPTION INFORMATION FOR VENTAVIS® INHALATION SOLUTION

ICD-10 Code *(required)*: _____ Dosing weight: _____ ☐ lbs ☐ kg Height: _____ ☐ in ☐ cm

2.5 mcg or 5 mcg (10 mcg/mL) inhalation via I-neb® AAD® System, as tolerated. 6 to 9 times per day during waking hours.

Start with 2.5 mcg × 1. If tolerated, go to 5 mcg (10 mcg/mL) ongoing. If not tolerated, resume 2.5 mcg.
If patient is maintained at 5 mcg (10 mcg/mL) dose and repeatedly experiences extended treatment times, consider transitioning to 5 mcg (20 mcg/mL).

☐ If patient is maintained at VENTAVIS® 5 mcg (10 mcg/mL) for 1 month, consider transitioning to VENTAVIS® 5 mcg (20 mcg/mL) starting at month 2, unless contacted by physician.

☐ Or please provide dosing instructions: _____

Dispense 1-month supply.

Refills (select one): ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11

Send one (1)* I-neb AAD System if this is an initial order.

**If the patient resides in a remote area that does not allow for timely delivery (delivery within 8 hours), two (2) I-neb AAD Systems will be dispensed.*

SHIP TO

☐ Patient home ☐ Prescriber office ☐ Other—Please specify address if different from patient home or prescriber office.

Other Address (no PO box): _____

City: _____ State: _____ ZIP: _____

Ship Attn: _____

NURSE SUPPORT

Nursing services requested. Skilled nursing visit for patient education related to therapy and disease state, administration of medication as prescribed, and assessment of general status and response to therapy. One to 3 visits to be provided for patient training.

Patient Training: ☐ Specialty pharmacy to conduct initial patient training; initial training with I-neb Insight™ breathing monitor required.
☐ PAH treatment center to conduct initial patient training; initial training with I-neb Insight™ breathing monitor required.

Or please provide patient training instructions: _____

Follow-up nursing visits as ordered by physician to ensure patient is proficient in medication use and I-neb AAD System administration.

☐ **Check this box to order a nursing visit to conduct an I-neb Insight™ download to measure patient compliance and assess patient breathing technique.**

_____ **week(s) post therapy initiation.**

HCP AUTHORIZATION

My signature below indicates that I have read, understand, and agree to the Johnson & Johnson Patient Assistance Foundation, Inc. policy and the terms of Program participation on page 9 of the Program Application.

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute	May Substitute / Product Selection Permitted / Submission Permissible
▶ _____	▶ _____
Prescriber's Signature Date	Prescriber's Signature Date

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The prescriber 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.

Print Form

Patient Assistance Program Application

PATIENT DECLARATION AND PATIENT AUTHORIZATION TO SHARE HEALTH INFORMATION

Please read, sign and date on page 2, Patient Section 4.

I promise:

- The information on this form is correct and complete including all copies of documents proving my income.
- The product(s) provided under this patient assistance program will not be sold or traded.
- I will notify the Johnson & Johnson Patient Assistance Foundation, Inc. (JJPAF) Patient Assistance Program ("Program") within thirty (30) days if there is any change in the status of my eligibility (related to changes in income or health coverage) to receive products through this program. This includes a change in my eligibility to participate in the Medicare program due to changes in my age or disability status or my enrollment in Medicare Part D.
- Not to attempt to claim or submit any costs associated with the medicine(s) I receive under the Johnson & Johnson Patient Assistance Foundation, Inc. Patient Assistance Program to any person or entity, including my Medicare Part D plan.
- Not to seek true out-of-pocket (TrOOP) credit under the Medicare Part D program for the cost of the medicine(s) I receive under this program.

I authorize the following communications:

- Specifically, I authorize JJPAF to contact me to request my assistance with analysis related to the quality and efficacy of the JJPAF Program.
- When signing this application, I am agreeing to allow the manufacturer or its agent to contact me or my healthcare provider for additional information, if needed, to evaluate any adverse event or product complaint I or my provider reported on my behalf.
- The Program to contact my insurer, other potential funding sources, including the Centers for Medicare and Medicaid Services, social workers, or patient advocacy organizations on my behalf in order to determine if I am eligible for health insurance coverage or other funds, and disclose to them information contained in my JJPAF Program application or information about my prescribed medications and medical condition that has been provided by my physician, healthcare provider, or pharmacist.

I understand that JJPAF and the vendors associated with administrating the Program (collectively the "Program Administrators"):

- Reserve the right without notice to change the application form, change the Program or Program criteria, or terminate my enrollment at any time, without notice.
- May request and obtain information about my or my family's income, including verification of my income through third-party sources.

Patient Authorization To Share Health Information: By signing on page 2, I hereby authorize:

- My doctor(s), pharmacy and other healthcare providers, and my health plan or insurers ("Entities") to disclose to and share with JJPAF, the Program Administrators and their affiliates, agents, contractors, representatives, service providers, and assignees ("JJPAF Recipients"), my individually identifiable health information, which may include my full name, demographic information, financial information, and information related to medical condition, treatment, care management, health insurance and benefits, medication history, and prescriptions (collectively, "Health Information"), whether in written or verbal form, including portions of my medical record.
- The JJPAF Recipients to access, obtain, use, disclose, receive, and maintain my Health Information for purposes of processing this Application, verifying the information provided in this Application, assisting in the identification of or determining eligibility under the Program and other patient assistance resources, investigating and verifying my insurance benefits, coordinating the dispensing and delivery of medication, and conducting the additional services described above and to run the Program, including internal business purposes.

In addition, by signing on page 2, I understand and agree that:

- I may refuse to sign the form on page 2. This authorization is voluntary, but if I refuse to sign this form, I know that this means that I may no longer be eligible to receive assistance from the Program. I understand that my doctor(s), pharmacy and other healthcare providers, and my health plan or insurers may not condition the provision of my treatment, or coverage of my benefits, on my signing this authorization.
- Health Information released under this authorization may no longer be protected by state and federal law, including the Health Insurance Portability and Accountability Act (HIPAA).
- My pharmacy may receive compensation in connection with sharing my information with JJPAF as allowed under this Authorization.
- The information provided in this application may be subject to random audits and verification, and that during such audits and verification processes, I may be asked for additional supporting documentation and will comply with such requests.
- I may withdraw my authorization at any time by mailing a written withdrawal to JJPAF at 610 Crescent Executive Court, Suite 200, Lake Mary, FL 32746, however, such withdrawal will not have an impact on any actions that have already been taken in reliance on this authorization.
- This authorization will last until I am no longer participating in the Program or sooner as limited by applicable state law.
- I have a right to receive a copy of this authorization.

Patient Assistance Program Application

Johnson & Johnson PATIENT ASSISTANCE FOUNDATION, INC.

HEALTHCARE PROFESSIONAL AUTHORIZATION: JJPAF POLICY AND TERMS & CONDITIONS AGREEMENT

Please read, sign and date in the "HCP Authorization" section(s) for the product(s) you have prescribed.

Johnson & Johnson Patient Assistance Foundation, Inc. (JJPAF) policy prohibits Healthcare Professionals (HCPs) from charging patients any fee for enrollment or other activities associated solely with the patient's participation in the Patient Assistance Program ("Program").

- JJPAF requests that HCPs not charge the patient for those professional services associated with this regimen not covered by the patient's health insurer.
- No claim may be made to any third-party payer (e.g., Medicaid, Medicare, private insurance, etc.) for payment for product provided under the Program.
- In accordance with the CMS Medicare Policy Manual, CMS will not reimburse you for any free product donated from JJPAF. In addition, in accordance with our eligibility criteria, Medicare Part B patients may receive free physician-administered product from JJPAF when such product is not covered by CMS. In such a case, and according to CMS policy, claims for administration services may not be reimbursed. You accept product from JJPAF with this understanding.
- The products(s) provided under the Program may not be sold or traded and may not be returned for credit.
- The JJPAF Program is limited to patients being treated on an outpatient basis.
- JJPAF and the vendors associated with administrating the Program (collectively, the "Program Administrators") reserve the right to request additional information if needed and to change or terminate the Program at any time, without notice.
- JJPAF and the Program Administrators reserve the right to refuse to distribute the medications under this program to any patient or facility at any time, without notice.

Indicate your agreement to the terms of the JJPAF Program participation by signing in the "HCP Authorization" section(s) for the product(s) you have prescribed. Your signature is required to confirm to JJPAF:

- There is a valid medical need for this patient's prescription.
- I authorize JJPAF or its affiliated companies or subcontractors to forward the patient's prescription to a dispensing pharmacy on behalf of the patient.
- I authorize JJPAF to use my provider information, including National Provider ID # to determine a patient's eligibility in the Program.
- That to the best of your knowledge this patient does not have prescription drug insurance coverage for the product(s) listed above.
- For OPSUMIT®* (female patients only), the healthcare provider will enroll in the OPSUMIT® Risk Evaluation and Mitigation Strategy (REMS) and comply with requirements to prescribe OPSUMIT® and the patient will be enrolled in the OPSUMIT® REMS.
- For TRACLEER®*, the healthcare provider will enroll in the Bosentan Risk Evaluation and Mitigation Strategy (REMS) and comply with requirements to prescribe TRACLEER® and the patient will be enrolled in the Bosentan REMS.
- You are not prohibited from participating in Federally funded healthcare programs nor are you on the List of Excluded Individuals/Entities maintained by the HHS Office of Inspector General.
- That the medication(s) provided to you by the Program will not be provided or dispensed to any other person.
- I have a signed copy on file of my patient's current and completed patient authorization to share health information in accordance with HIPAA, or any other authorization or consent required by law, so that you may share patient health information with the Program, including the JJPAF Recipients.
- I understand that the information provided in this application may be subject to random audits and verification and that, during such audits and verification processes, I may be asked for additional supporting documentation and will comply with such requests.

***Please read full Prescribing Information, including Boxed Warning.**