withMe

Enrollment and Prescription Form Fax Cover Sheet





Fax the following to J&J withMe at 866-279-0669:

- OPSUMIT® Enrollment and Prescription Form, including the Johnson & Johnson Patient Support Program
 Patient Authorization
- 2. Please provide copies of all medical and prescription insurance cards (front and back)
- 3. If needed, please attach list of concomitant medicines
- 4. If needed, please attach list of known drug allergies



Requirements for OPSUMIT® Voucher Program

Please provide all of the patient's concomitant medicines in **Section 3**: Diagnosis & Prescription Information. Include PAH medicines and all medicines for other comorbidities. If you prefer, you can fax the medicine list.



Patient Authorization Requirements

Patients to complete and sign all pages of the attached Patient Support Program Patient Authorization Form. Please fax the completed and signed Patient Authorization with the OPSUMIT® Enrollment and Prescription Form. If necessary, a patient can submit a digital version of the Patient Authorization at <u>PAHconsent.com</u> or by scanning the QR code.



Data rate may appl

Fax the completed and signed Enrollment and Prescription Form to J&J withMe at 866-279-0669. You can also request benefits investigations on the Provider Portal at <u>PATHwatch.net</u>.

Once a decision has been made to prescribe OPSUMIT® and your patient has signed the Patient Authorization form J&J withMe is a suite of access, affordability, and treatment support for your patients

Access Support to help navigate payer processes by verifying insurance coverage and providing reimbursement information.

Affordability Support to help your patients start and stay on the OPSUMIT® you prescribe by providing affordability options that may be available.

Treatment Support, including PAH Companion withMe, to help your patients get informed and stay on prescribed OPSUMIT®.

If you have questions, call a J&J withMe Care Coordinator at 866-228-3546, Monday–Friday, 8:00 AM–8:00 PM ET. Multilingual phone support available. Visit <u>JNJwithMe.com</u>.

					cp-1404/1v/
Date: I	ax number: 866-279-0669				
-rom:		Faci	lity name:		
acility contact:					
Completed OPSUMIT® Enrollmo	ent and Prescription Form enclose	d.			
Number of pages (including cove	r):				
Specialty Pharmacy preference:	☐ Accredo Health Group, Inc.	☐ CenterWell	☐ CVS/specialty	☐ Kaiser Permanente	
Please note: The Specialty Pharr vill ultimately determine where th	nacy preference above will be validate ne enrollment is sent.	ated through the s	andard benefit verifi	cation process. Other factors, lik	e payer mandates,
Comments:					

Contact J&J withMe at 866-228-3546.

The patient support and resources provided by J&J withMe and PAH Companion withMe are 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 a J&J medicine.

Information about your patient's insurance coverage, cost support options, and treatment support is given by service providers for J&J withMe. The information you get does not require you or your patient to use any Johnson & Johnson product. Because the information we give you comes from outside sources, J&J withMe cannot promise the information will be complete.

Please read full <u>Prescribing Information</u>, including BOXED WARNING, and <u>Medication Guide</u> for OPSUMIT®. Provide the Medication Guide to your patients and encourage discussion.

J&J

UPDATE 05.25

withMe

Enrollment and Prescription Form



The information you provide will be used by Johnson & Johnson Health Care Systems Inc., our affiliates, and our service providers for your patient's enrollment and participation in J&J withMe. Our <u>Privacy Policy</u> further governs the use of the information you provide.

Fields marked with an (*) are required.				cp-140471v7
1. Patient Information (please print)				
*First Name	MI	*Last Name		
*Sex at Birth Male Female *Birth Date	(MM/DD/YYYY)	Preferred Language	ı □ Spanish □ Other	
*Address	,	*City	*State*ZIP	
Email Address				
*Primary Phone #		Iternate Phone #	☐ Home ☐ Cell ☐ Work	□ам □рм
Ok to leave message with: □ Care Partner □ Lega	lly authorized representative (if needed, p	rovide contact information below)		Best time to call
Full Name	Phone #	Email	I Address	
Primary Insurance	Group #	BIN #	PCN	
2. Prescriber Information (please prin	•			
*Prescriber's First Name	*Prescriber's Last	Name	Specialty	
*Prescriber NPI State License #				
*Address				
Office Contact Name		-		
Office Contact Email Address				
3. Diagnosis & Prescription Informa		rax #		
☐ Idiopathic PAH ☐ Heritable PAH OPSUMIT® (macitentan) 10 mg on Concomitant Medicines: Please check only attach separate list of concomitant drugs and ☐ No other medicines ☐ List all other medicines	nce daily for oral administration one box in each section and if needed, d known drug allergies.	NDC 66215-501-30 *Qua Drug Allergies: Please che □ No known drug allergies	eck only one box.	
4. OPSUMIT® Voucher Program - Di	enoneing pharmacy may contact you f	or additional information		
Dispense OPSUMIT® Voucher Program A free 30-day trial off to continue treatment	fer is available for eligible patients to help ther	em become familiar with OPSUMIT®. At 1 rst 30-day supply of OPSUMIT®. See pr	the conclusion of the program, you and your patie rogram requirements at <u>JNJwithMe.com/Opsumi</u>	
5. Shipping				
*Ship to (As allowable by law): Patient home	, –	, – ,	needed, provide shipping information below)	
			*State*ZIP	
6. Prescriber Signature – Prescripti		•		
I have made the determination, based on my indepen of this patient. I authorize Johnson & Johnson Heal appropriate pharmacy designated by the patient util eligibility and benefits. PRESCRIBER SIGNATURE R When commercial insurance coverage is delayed >5 to program requirements at JNJwithMe.com/Opsumit action described in the requirements for my patient.	th Care Systems Inc., its affiliates, agents, ilizing their benefit plan. This authorization EEQUIRED TO VALIDATE PRESCRIPTIONS pusiness days or denied, J&J withMe offers E-PAH-Link. By enrolling my patient for this	and contractors to act on my behalf includes permitting J&J to communi S. Prescriber attests this is his/her le eligible patients OPSUMIT® at no cos s support, I certify that I have read an	For the limited purposes of transmitting this paicate to payers on my behalf to confirm this paical signature (NO STAMPS). Prescriptions must until their commercial insurance covers the medid agree to the program requirements and will tr	prescription to the atient's health plan ust be faxed. edicine. Please see
*SIGN HERE Dispe	ense as Written	ORSubstit	itution Allowed	

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

Please read full <u>Prescribing Information</u>, including BOXED WARNING, and <u>Medication Guide</u> for OPSUMIT®. Provide the Medication Guide to your patients and encourage discussion.

Johnson &Johnson

Patient support program patient authorization form

Why should I sign this Form?

This Form gives your Healthcare Providers permission to use and share your medical information with the patient support programs offered by Johnson & Johnson.

Section 1 What health information am I sharing and with whom?

I give permission for my Healthcare Providers and Insurers (eg, my health insurance plans) to share my Protected Health Information, as described on this Form.

- My Protected Health Information includes information related to: my medical condition, treatment, prescriptions, and health insurance coverage
- ♣ My Healthcare Providers may include: physicians, pharmacists, specialty pharmacies, other healthcare providers, and staff members at my healthcare providers' offices

I give permission to these people or groups to receive and use my Protected Health Information (collectively "J&J"):

- Johnson & Johnson Health Care Systems Inc., its affiliated companies, agents, and representatives
- Providers of other sources of funding.
 This includes foundations and co-pay assistance providers
- Service providers for the patient support programs.
 This includes subcontractors or healthcare providers helping J&J run the programs
- Service providers maintaining, transmitting, de-identifying, aggregating, or analyzing data from J&J's support programs
- My Protected Health Information may be shared by J&J with these people and groups: my Insurers, my Healthcare Providers, any other people given permission to receive and use my Protected Health Information (as mentioned above), anyone I give permission to as an additional contact, and service providers who review data from J&J's patient support programs
- J&J and the other groups on this Form may share information about me in 2 ways: as permitted on this Form, and if any information that identifies me is removed from what has been shared

Section 2 How can giving permission help with patient support programs and access?

I give permission to J&J to receive, use, and share my Protected Health Information to:

- See if I qualify for, sign me up for, contact me about, and provide services relating to J&J's patient support programs. This includes in-home services
- Manage J&J's patient support programs
- Give me resources and information related to my J&J medicine in connection with J&J's patient support programs. This includes educational and adherence materials
- Communicate with my Healthcare Providers about access, reimbursement, and fulfillment for my J&J medicine

- Inform my Healthcare Provider that I am enrolled in J&J's patient support programs
- Help verify and coordinate coverage for J&J medicines with my Insurers and Healthcare Providers
- Help with prescription or treatment location and associated scheduling
- Conduct analysis to help J&J evaluate, create, and improve their patient support services and products for patients prescribed J&J medicines
- Share information from J&J's patient support programs that may be useful for my care

Section 3 What should I understand before signing this Form?

I understand that:

- J&J will use reasonable efforts to keep my information private. But, once my Protected Health Information is disclosed as allowed on this Form, it may no longer be protected by federal privacy laws
- 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 in or receive assistance from J&J's patient support programs
- The following groups may be paid by J&J for their services and data, including Protected Health Information:
 - Pharmacies that dispense and ship my medicine
 - Service providers for J&J's patient support programs
- This Form will remain in effect 10 years from the date I signed below, except if:
 - State law requires a shorter time, or
 - I am no longer in any patient support program from J&J

- lnformation collected before that date may continue to be used for the purposes noted in this Form
 - I may cancel the permissions given by this Form at any time by letting J&J know in writing at: J&J withMe, 6931 Arlington Road, Suite 400, Bethesda, MD 20814
 - 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 J&J
 - If I cancel my permission, it will not affect how J&J uses and shares my Protected Health Information received by J&J before my cancellation
 - I may request a copy of this Form

Patient name (print)		DOB (mm/dd/yyyy)		
Email Address		Phone Number		
Patient Address				
Patient signature			Date	
If patient cannot sign, p	atient's legally authorized represent	ative must sign l	pelow:	
	Print nameally authorized to sign for patient)		Date	
Describe relationship to	patient and authority to make medic	cal decisions for	patient:	



Please visit <u>JNJwithMe.com</u> for information about J&J's patient support programs





Helpful resources you can sign up for (optional)

Permission for communications outside of J&J's patient support programs:

- ☐ Yes, I would like to receive communications about my J&J medicine
- ☐ Yes, I would like to receive communications about other products and services from J&J

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 J&J's patient support programs or to receive any other communications I have selected. Cell phone number: ______

For privacy rights and choices specific to California, Colorado, Connecticut, Utah, Virginia, and Washington residents, please see J&J's US Supplemental Privacy Notice available at InnovativeMedicine.JNJ.com/us/privacy-policy#supplemental

How to Complete and Return the Patient Authorization Form



Sign and return pages 1 and 2 of this Form to: (If optional resources are selected, complete and return page 3)



Or, eSign a digital Form:

Us In your healthcare provider's office

At PAHconsent.com or scan this QR code



Data rates may apply.