

# Patient Assistance Program (PAP) Application

## 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), Monday through Friday, 8:00 AM – 8:00 PM ET.

## PULMONARY ARTERIAL HYPERTENSION (PAH) MEDICATIONS AVAILABLE THROUGH THE PAP



The Johnson & Johnson Patient Assistance Foundation, Inc. (JJPAF) is an independent, nonprofit organization. JJPAF gives eligible patients free prescription medicines donated by Johnson & Johnson 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 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

# Patient Assistance Program Application

**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: \_\_\_\_\_

<input type="checkbox"/> Check if no insurance	ID/Policy #	Group #	Phone
<input type="checkbox"/> Prescription Insurance/Medicare Part D Plan Plan Name: _____ Fax: _____ Rx BIN #: _____ Rx PCN: _____			
<input type="checkbox"/> Private/Commercial Insurance			
<input type="checkbox"/> Medicaid			
<input type="checkbox"/> Medicare Part B			
<input type="checkbox"/> Medicare Advantage			
<input type="checkbox"/> Veterans Administration			
<input type="checkbox"/> ADAP AIDS			
<input type="checkbox"/> SPAP State Patient Assistance Program			
<input type="checkbox"/> 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.

<b>CHECK THE BOX:</b>	<p><b>Applicant Financial Verification Authorization</b></p> <p><input type="checkbox"/> 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.</p>
<b>PLEASE COMPLETE, SIGN &amp; DATE:</b>	<p>Patient Name (print): _____ Date: _____</p> <p>Authorized Representative Name (print if applicable): _____</p> <p>Relationship to Patient (print if applicable): _____ Phone: _____</p> <p>_____                  Patient Signature/Authorized Representative Date: _____</p>

# Patient Assistance Program Application

**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): \_\_\_\_\_

*If you are a prescriber in New York, you must attach the prescription on your state official prescription form with this application.*

### 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

 \_\_\_\_\_  
Prescriber's Signature Date

May Substitute / Product Selection Permitted / Submission Permissible

 \_\_\_\_\_  
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.

# Patient Assistance Program Application

**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 66215-232-56)

**Directions for use and dispensing instructions:** Complete the fields below.

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

*If you are a prescriber in New York, you must attach the prescription on your state official prescription form with this application.*

**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
<div style="display: flex; justify-content: space-between; align-items: center;"> <div style="text-align: center;"> </div> <div style="flex-grow: 1; border-bottom: 1px solid black; margin-bottom: 5px;"></div> <div style="text-align: center;">                     Date                 </div> </div> <p style="margin-top: 5px; text-align: center;">Prescriber's Signature</p>	<div style="display: flex; justify-content: space-between; align-items: center;"> <div style="text-align: center;"> </div> <div style="flex-grow: 1; border-bottom: 1px solid black; margin-bottom: 5px;"></div> <div style="text-align: center;">                     Date                 </div> </div> <p style="margin-top: 5px; text-align: center;">Prescriber's Signature</p>

**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.**

# Patient Assistance Program Application

**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:** \_\_\_\_\_

*If you are a prescriber in New York, you must attach the prescription on your state official prescription form with this application.*

**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**

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
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> _____</div> <div style="width: 45%;"> _____</div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <span>Prescriber's Signature</span> <span>Date</span> </div>	<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> _____</div> <div style="width: 45%;"> _____</div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <span>Prescriber's Signature</span> <span>Date</span> </div>

**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.

# Patient Assistance Program Application

**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

**Strength:**  VELETRI® 0.5 mg/mL (10 mL/vial) NDC 66215-403-01  VELETRI® 1.5 mg/mL (10 mL/vial) NDC 66215-402-01

### Dosage/Directions:

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

*If you are a prescriber in New York, you must attach the prescription on your state official prescription form with this application.*

### 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.



## 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 & 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

### 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 product(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 administering 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 transmit the patient's prescription by any means under applicable law 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 my 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.
- I am not prohibited from participating in Federally funded healthcare programs nor am I on the List of Excluded Individuals/Entities maintained by the HHS Office of Inspector General.
- That the medication(s) provided to me 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 I 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.