INSTRUCTIONS FOR ENROLLMENT

Patient Assistance Enrollment Form (For Pulmonary Hypertension)

Janssen believes that access and affordability challenges shouldn't stand in the way of patients and their medications. Janssen medications may be provided free of charge to eligible patients who have inadequate coverage through commercial, employer group, or government insurance plans and are not supported by other Janssen offerings.

ENROLLMENT CHECKLIST

- ☐ Complete all sections of page 2 and sign page 3
- ☐ Review and sign the Patient Authorization on pages 4 & 5 or by going to **PAHconsent.com**. If you have already completed a Janssen Patient Support Programs Patient Authorization, you do not need to do it again
- ☐ Gather any required supporting documents to determine what documents you need to include (if any)

SUPPORTING DOCUMENTS

- ☐ Insurance information: copies of the front and back of all insurance card(s) (eg, medical, pharmacy, etc. if you did not complete section 4 on page 2)
- ☐ Medicare Part D Patients only: Submit a report from your pharmacy **OR** an Explanation of Benefits (EOB) statement from your insurer that shows your out-of-pocket costs for the current year

Complete this Patient Assistance Enrollment Form to the best of your abilities, including the supporting documents and fax to: 866-279-0669. Any required information you did not provide with your initial submission will cause delays in processing your application. Healthcare providers may assist patients or caregivers in populating and submitting this form. A signature from the patient or their legally authorized representative is required where indicated on the form. For assistance on how to complete the form or questions about the program, call **866-228-3546**, Monday through Friday, 8:00 AM to 8:00 PM ET.

Medications Available Through This Form

OPSUMIT®* (macitentan) Tablets

TRACLEER®* (bosentan) Tablets

UPTRAVI®† (selexipag) Tablets

VELETRI®† (epoprostenol) for Injection

VENTAVIS®† (iloprost) Inhalation solution

*Please see Important Safety Information, including BOXED WARNING, and full Prescribing Information available at **https://www.janssencarepath.com/patient/important-safety-information** and available from your Janssen representative.

†Please see Important Safety Information and full Prescribing Information available at **https://www.janssencarepath.com/patient/important-safety-information** and available from your Janssen representative.

A Janssen representative will contact the healthcare provider using the information provided to determine any additional information needed for the prescribed medication.

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Patient Assistance Enrollment Form (For Pulmonary Hypertension)

The information you provide will be used by Janssen Pharmaceuticals, Inc., our affiliates, and our service providers to determine your eligibility for and enroll you in the program. You may withdraw your request for these services by calling 866-228-3546. Our **Privacy Policy** further governs the use of the information you provide. By submitting this form, you indicate that you read, understand, and agree to these terms.

Fields marked with a (*) are required

1. Patient Information

*First Name: _____ *Last Name: _____ *Phone: _____

Email: _____ *Date of Birth (*mm/dd/yyyy*): _____ *Gender: _____

*Address Line 1: _____ Address Line 2: _____

*City: _____ *State: _____ *ZIP Code: _____

This is the address that all self-administered medication will be shipped to. For a change of address, please contact 866-228-3546 and also share the information with your healthcare provider.

2. Prescribing Healthcare Provider Information

*First Name: _____ *Last Name: _____ *Site Name: _____

*Address Line 1: _____ Address Line 2: _____

*City: _____ *State: _____ *ZIP Code: _____

*Phone: _____ *Fax: _____ Email: _____

***MEDICATION PRESCRIBED** *(Select all that apply)*

- ☐ **OPSUMIT®** (macitentan) Tablets
- ☐ **UPTRAVI®** (selexipag) Tablets
- ☐ **TRACLEER®** (bosentan) Tablets
- ☐ **VELETRI®** (epoprostenol) for Injection
- ☐ **VENTAVIS®** (iloprost) Inhalation Solution

3. Financial Information

***Total Gross Annual Income**

Entire household: $ _____

***Household Size**

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

(The credit check is required to confirm you meet the income eligibility. This will not impact patient's credit score.)

CHECK THE BOX: ☐

***Applicant Financial Verification Authorization:**
I also understand that Johnson & Johnson Health Care Systems Inc. (JJHCS) 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 JJHCS Program.

4. Insurance Information *(Complete for all available insurance OR submit copies of front and back of all insurance cards.)*

Medicare Part D patients only: Medicare ID #: _____

Primary Prescription Insurance: _____ Card BIN #: _____ Phone: _____

Cardholder Name (*First, MI, Last*): _____ Relationship to Cardholder: _____

Policy #: _____ Group #: _____

Primary Medical Insurance: _____ Phone: _____

Cardholder Name (*First, MI, Last*): _____ Relationship to Cardholder: _____

Policy #: _____ Group #: _____

Cardholder Employer Name: _____ Cardholder Employer Phone: _____

Address Line 1: _____ Address Line 2: _____

City: _____ State: _____ ZIP Code: _____

Fax: _____

If you are aware of an Assistance Diversion Program (ADP) being part of your insurance plan design, please provide the details below:

ADP Name: _____ Address: _____

City: _____ State: _____ ZIP Code: _____

Phone: _____ Fax: _____

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Patient Assistance Enrollment Form

I understand that JJHCS and third parties associated with administrating the Program on behalf of JJHCS (collectively, the "Program Administrators"):

- Reserve the right without notice to change the application form, change the Program or Program criteria, or to terminate my enrollment at any time;
- May request and obtain information about my or my family's income, including verification of my income, or my insurance coverage, including documentation of any insurance denials, and that the information may be requested from me, others acting on my behalf, or third-party sources;
- May request that I re-verify my eligibility to receive medicines under the Program

I certify that:

- All the information on this form and all the documentation submitted are complete and correct, and to the best of my knowledge, I meet the eligibility requirements for the submission of the application
- I am completing this application voluntarily. I have not been directed by my insurance company or by a non-medical professional to complete this application. I have not been offered any financial or other benefit by any third party in order to seek assistance from Johnson & Johnson Patient Healthcare Systems, Inc. (JJHCS) and I have not been told that any benefit will be denied or withheld (such as insurance coverage) if I do not complete this application
- I have completed this application myself or with the assistance of a legally authorized representative (such as a guardian), family member, caregiver, friend, healthcare provider or representative of a patient organization. If such assistance was provided, I have reviewed the application before submission to JJHCS to ensure all information is accurate and true. No other third party has assisted with the completion of this application
- The product(s) provided under this patient assistance program will not be sold or traded
- I will notify the Janssen Support Program within thirty (30) days if there is any change in my income or health insurance coverage. 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
- I will not attempt to claim or submit any costs associated with the medicine(s) I receive under the Janssen Support Program to any person or entity, including my Medicare Part D plan
- I will not 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

SIGN & DATE:

Patient Name (*print*): _____

Patient Sign Here: _____ Date (*mm/dd/yyyy*): _____

If patient cannot sign, patient's legally authorized representative must sign below:

By: _____ Print Name: _____ Date (*mm/dd/yyyy*): _____
(Signature of person legally authorized to sign for patient)

Describe relationship to patient and authority to make medical decisions for patient:

_____

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Patient Authorization Form

Patients should **(1)** read the Patient Authorization, **(2)** check the desired permission boxes, and **(3)** return the form to Janssen Patient Support Program.

Options to complete and return the form:

A. Download a copy, print, check the desired boxes, and sign. The completed form may be faxed to 866-279-0669 or mailed to Janssen CarePath, 6931 Arlington Road, Suite 400, Bethesda, MD 20814

B. Patients may also read, sign, and submit a digital version of this form at **PAHconsent.com**.

Patient Name: _____ Date of Birth (*mm/dd/yyyy*): _____

Patient Address: _____

City: _____ State: _____ ZIP Code: _____

Phone Number: _____ Email Address: _____

I give permission for each of my "Healthcare Providers" (eg, my physicians, pharmacists, specialty pharmacies, other healthcare providers, and their staff) and "Insurers" (eg, my health insurance plans) to share my Protected Health Information.

My "Protected Health Information" includes but is not limited to the following information related to my medical condition, treatment, prescriptions, and health insurance coverage.

The following person(s) or class of person(s) are given permission to receive and use my Protected Health Information (collectively "Janssen"):

- Johnson & Johnson Health Care Systems Inc., its affiliated companies, agents, and representatives
- Providers of other sources of funding, including foundations and co-pay assistance providers
- Service providers supporting or analyzing data from Janssen patient support programs

Specifically, I give permission to Janssen to receive, use, and share my Protected Health Information in order to:

- See if I qualify for, sign me up for, and contact me about Janssen patient support programs
- Manage the Janssen patient support programs
- Give me educational and adherence materials, information, and resources related to my Janssen medication in connection with Janssen patient support programs
- Communicate with my healthcare provider regarding access to, reimbursement for, and fulfillment of my Janssen medication, and to confirm to my healthcare provider that support has been provided by the Janssen patient support programs
- Verify, assist with, and coordinate my coverage for my Janssen medication with my Insurers and healthcare provider
- Coordinate prescription or treatment location and associated scheduling
- Conduct analysis to help Janssen evaluate, create, and improve its products, services, and customer support for patients prescribed Janssen medications
- Share and give access to information created by the Janssen patient support programs that may be useful for my care

I understand that my Protected Health Information may be shared by Janssen for the uses written in this form to:

- My Insurers
- My healthcare provider
- Any of the persons given permission to receive and use my Protected Health Information as mentioned above
- Any individual I give permission as an additional contact

SUBMIT THIS PAGE

Patient Authorization Form

I understand that my Protected Health Information will not be used or shared by Janssen for any other use without my permission. Janssen may share information about me where legally allowed or if any information that specifically identifies me is removed. I understand that Janssen will make every effort to keep my information private. Further, I understand that if my information is accidentally shared, federal privacy laws do not require that the person/party receiving it not share the information further and that such information provided to a third party may no longer be protected by federal privacy laws. I understand that my pharmacy may receive compensation in connection with sharing my information with Janssen as allowed under this Authorization.

I understand that I am not required to sign this Form. My choice about whether to sign will not change how my healthcare provider 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 or receive assistance from Janssen's patient support programs.

This Form will remain in effect 10 years from the date of signature, except where state law requires a shorter time, or until I am no longer participating in any Janssen patient support programs. Information collected before that date may continue to be used for the purposes set forth in this Form.

I understand that I may cancel the permissions given by this Form at any time by letting Janssen know, in writing, at: Janssen CarePath, 6931 Arlington Road, Suite 400, Bethesda, MD 20814.

I can also cancel my permission by letting my healthcare provider and Insurers know, in writing, that I do not want them to share any information with Janssen.

I further understand that if I cancel my permission, it will not affect how Janssen uses and shares my Protected Health Information received by Janssen prior to my cancellation.

I understand I may request a copy of this Form.

Permission for communications outside of Janssen patient support programs:

☐ Yes, I would like to receive communications relating to my Janssen medication.

☐ Yes, I would like to receive communications relating to other Janssen products and services.

For privacy rights and choices specific to California residents, please see Janssen's California privacy notice available at **https://www.janssen.com/us/privacy-policy#california**.

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 the Janssen patient support programs or to receive any other communications I have selected.

Cell Phone Number: _____

SIGN & DATE:

Patient Name (*print*): _____

Patient Signature: _____ Date (*mm/dd/yyyy*): _____

If patient cannot sign, patient's legally authorized representative must sign below:

By: _____ Print Name: _____ Date (*mm/dd/yyyy*): _____
(Signature of person legally authorized to sign for patient)

Describe relationship to patient and authority to make medical decisions for patient:

_____

Terms & Conditions

PATIENT ASSISTANCE PROGRAM

You may be eligible to receive your Janssen medication(s) free of charge for up to one year if you have been prescribed a Janssen medication, have a financial hardship, and are currently enrolled in government, commercial, or employer group health insurance.

You must meet the eligibility and income requirements to qualify for the patient assistance program.

You are not eligible for free Janssen medication if your health insurance will cover the cost of your Janssen-prescribed medication if this application is denied. Some employers, insurers, and other companies force patients to apply for medically necessary medications from free product programs instead of covering such medications directly and immediately through insurance, which could lead to delays in care and discriminate against lower-income patients. These types of "Assistance Diversion Programs" are generally established by companies that profit by diverting resources away from patients in need. An Assistance Diversion Program is any insurer, employer, or third-party program that withholds coverage or payment for Patient's medically necessary drug until Patient has completed an application for free product assistance. Assistance Diversion Programs are prohibited by Janssen to make sure that help is available for patients with no safety net in place. Your insurer must submit a Patient Eligibility Certification form to confirm that your drug coverage is not subject to an Assistance Diversion Program.

You may not seek payment for the value of Janssen medications received from this program from any health plan, patient assistance foundation, flexible spending account, or healthcare savings account.

Before you enroll in the patient assistance program, it is important you understand that you will be asked to provide personal information that may include your name, address, phone number, email address, financial information, and information related to your prescription medication insurance and treatment. This information will be used by Janssen Pharmaceuticals, Inc., and its service providers to determine your eligibility for, enroll you in, and administer the program. The information will also be used to learn more about the people who use the program, to improve the program, and will be shared with service providers supporting the program.

If you have Medicare Prescription Drug Coverage (Part D) you may be asked to attest to or submit a report from your pharmacy or an Explanation of Benefits (EOB) statement from your insurer that shows your out-of-pocket costs for the current year. To qualify for the program, 4% of your gross annual household income must be spent on out-of-pocket prescription expenses for you and/or other members of your household.

This program offer may not be used with any other coupon, discount, prescription savings card, free trial, or other offer. Offer good only in the United States and its territories. Void where prohibited, taxed, or limited by law. Program terms will expire at the end of each calendar year and may change or end without notice, including in specific states.

You may end your participation in the program at any time by calling 833-742-0791, Monday through Friday, 8:00 AM to 8:00 PM ET.