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 pages 7 and 8, then complete all relevant patient information on page 2. Please **sign and date** as required on page 2
- ☐ **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, sign and date in the "HCP Authorization" section(s) for the product(s) they have prescribed, and submit their completed portion via mail or fax
- ☐ Submit completed page 2 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

Opsumit® macitentan tablets 10 mg

Opsynvi® macitentan/tadalafil 10 mg/40 mg tablets

Tracleer® BOSENTAN 62.5 mg/125 mg Tablets 32 mg Tablets for Oral Suspension

Uptravi® selexipag tablets | 200-1600 mcg

VELETRI® epoprostenol for Injection

ELIGIBILITY STANDARDS: If you have any insurance, JanssenCarePath.com may have some options for support of insured patients.

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. JJPAF provides free medicines when financially needy patients have no other way to access their prescribed medicines.

JJPAF is not insurance and does not bill insurance for the prescription medicines. JJPAF does not partner with any health insurers or healthcare provider networks.

Our free prescription medicine program is called the Johnson & Johnson Patient Assistance Foundation, Inc. Patient Assistance Program (referred to in this application as the "Program"). No fee is charged for participation in the Program.

You may be eligible to receive a PAH medication under our 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)
  - The current eligibility income requirements are available at: https://www.jjpaf.org/pah/eligibility
- You don't have insurance
- You live in the United States or a U.S. territory
- You are being treated by a U.S. licensed doctor as an outpatient
- You have completed the application and submitted all necessary documentation

Please read through the application and make sure that you meet all the eligibility requirements and can provide all the necessary documentation when you submit the application. JJPAF cannot process an incomplete application.

IMPORTANT: JJPAF is a charity. JJPAF provides free medicines to patients in need. Submitting an application that includes information that you know is false or misleading in order to obtain assistance from the charity could constitute fraud. Applicants who knowingly submit such false information may be subject to legal action.

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Patient Assistance Program (PAP) 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 *(Indicate your federal tax filing status below* **ONLY** *if you do not check the box in Section 4 authorizing JJPAF to obtain a credit report or investigative credit report.)*

☐ 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 Coverage

The Program only provides PAH medications at no cost to patients who do not have insurance. Before you can be eligible for free medicine from the Program, you must be able to show that you do not have insurance and you cannot get assistance from other sources, including other insurance such as Medicaid that is available at no or minimal cost or assistance from other charities. **If you are not sure what other sources might exist, please call JJPAF and a JJPAF representative will help you.**

Please check the box below to confirm you have no insurance and no access to other free or minimal cost assistance. JJPAF may ask for documentation confirming your current healthcare coverage before a determination can be made about your eligibility for the Program.

CHECK THE BOX: ☐ I have no insurance and have checked eligibility requirements or applied to all available options for free or minimal cost insurance or other assistance.

4 Patient Declaration/Authorization to Assign Representative for Program Enrollment

Patient 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 pages 7 and 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, 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. I acknowledge and agree that JJPAF may request documentation confirming that the representative has the appropriate authority to speak on my behalf. I further understand that I remain responsible for the information submitted on my behalf by any authorized representative, including any misrepresentations or other false information.

CHECK THE BOX: ☐

Applicant Financial Verification Authorization

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

I 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 (PAP) 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 / OPSYNVI®* (macitentan/tadalafil) 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 – COMPLETE PRESCRIPTION FOR OPSUMIT® OR OPSYNVI® BELOW

PRESCRIPTION INFORMATION FOR OPSUMIT® TABLETS ICD-10 Code: _____

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

Instructions for use including route of administration and frequency *(required)*: _____

Quantity *(required)*: _____ Refills *(required)*: _____

OR

PRESCRIPTION INFORMATION FOR OPSYNVI® TABLETS ICD-10 Code: _____

Select all that apply:

☐ **OPSYNVI® 10 mg/20 mg tablets** NDC 66215-812-30

Instructions for use including route of administration and frequency *(required)*: _____

Quantity *(required)*: _____ Refills *(required)*: _____

☐ **OPSYNVI® 10 mg/40 mg tablets** NDC 66215-814-30

Instructions for use including route of administration and frequency *(required)*: _____

Quantity *(required)*: _____ Refills *(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	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.**

Print Form

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Patient Assistance Program (PAP) 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 66215-232-56)
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
▶ _____	▶ _____
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.**

Print Form

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Patient Assistance Program (PAP) 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:** _____

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
▶ _____	▶ _____
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 (PAP) 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

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.

Print Form

PATIENT DECLARATION AND PATIENT AUTHORIZATION TO SHARE HEALTH INFORMATION

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

I certify that:

- The information on this form is correct and complete including all copies of documents proving my income and, to the best of my knowledge, I meet the eligibility requirements for patient assistance and have complied with all 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 the Johnson & Johnson Patient Assistance Foundation, Inc. (JJPAF) 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, health care provider or representative of a patient organization. If such assistance was provided, I have reviewed the application before submission to JJPAF to ensure all information is accurate and true. No other third party has assisted with the completion of this application.
- I have tried to get other free or minimal cost insurance coverage or help from other sources of assistance (either in the form of financial assistance or free medicines) but have not been able to do so.
- The product(s) provided under this patient assistance program will not be sold or traded.
- I will notify the JJPAF Patient Assistance 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 JJPAF Patient Assistance Program to any person or entity.

I fully understand that:

- JJPAF is an independent charity that operates to provide assistance in the form of medically necessary free medicines to financially needy patients who have no other way to access such drugs; JJPAF will rely on the information provided in this application to determine whether I am eligible for assistance from the charity; the knowing submission of an application that includes false information in order to obtain assistance from the charity could constitute fraud; and JJPAF has the right to report fraud to government authorities or otherwise take legal action to protect its charitable assets from fraudulent activity.

I authorize the following communications:

- JJPAF or its agents contacting insurers, other potential funding sources – including the Centers for Medicare & Medicaid Services, state Medicaid programs or other charities, social workers, or patient advocacy organizations on my behalf in order to confirm that I do not currently have health insurance and to determine if I am eligible for health insurance coverage or other funds, and disclose to them information contained in my Program application or information about my prescribed medications and medical condition that has been provided by my physician, healthcare provider, or pharmacist.
- JJPAF or its agents contacting me to request my feedback on the quality and efficacy of the JJPAF Program.
- The company who made my medicine or its agents contacting 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.

PATIENT DECLARATION AND PATIENT AUTHORIZATION TO SHARE HEALTH INFORMATION (CONT'D)

I understand that JJPAF and third parties associated with administrating the Program on behalf of JJPAF (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 lack of insurance coverage 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.

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

- My doctor(s), pharmacy and other healthcare providers, ("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, 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; assessing eligibility for no or low cost insurance options, such as Medicaid; coordinating the dispensing and delivery of medication; assessing and communicating the availability of other third party patient assistance resources, including programs offered by the company that manufacturers my medicine or patient organizations that provide a range of patient assistance; auditing for compliance with Program requirements; replace with: conducting the additional services described above; running the Program; and undertaking other internal business purposes.
- The JJPAF Recipients to disclose and share with the contractors and service providers of the company that made my medicine my individually identifiable health information for the purpose of providing Nurse Support Services if I have chosen to receive those services.

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, may not condition the provision of my treatment, or coverage of my benefits, on my signing this authorization.
- My pharmacy may receive compensation in connection with sharing my information with the JJPAF as allowed under 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).
- 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 (PAP) 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 administration of product provided by JJPAF if those services are 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.
- 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 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 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 OPSUMIT®* (female patients only), the healthcare provider will certify in the Macitentan-Containing Products Risk Evaluation and Mitigation Strategy (REMS) and comply with requirements to prescribe OPSUMIT® and the patient will be enrolled in the Macitentan-Containing Products REMS.
- For OPSYNVI®* (female patients only), the healthcare provider will certify in the Macitentan-Containing Products Risk Evaluation and Mitigation Strategy (REMS) and comply with requirements to prescribe OPSYNVI® and the patient will be enrolled in the Macitentan-Containing Products REMS.
- For TRACLEER®*, the healthcare provider will certify 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 or state 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. I further understand that JJPAF may suspend the provision of free product to my patients during or as the result of such audits.

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

