INSTRUCTIONS FOR ENROLLMENT

Johnson & Johnson Patient Assistance Program Patient Enrollment Form (For Pulmonary Hypertension)

Johnson & Johnson (J&J) believes that access and affordability challenges shouldn't stand in the way of patients and their medicines. Medicines from J&J may be provided free of charge to eligible patients who are uninsured or have inadequate coverage through commercial, employer group, or government insurance coverage and are not supported by other offerings from J&J.

ENROLLMENT CHECKLIST

- ☐ Complete all sections of page 2 and sign page 3
- ☐ Review and sign the Patient Authorization on pages 4 and 5 or by going to **PAHconsent.com**. If you have already completed a Janssen Patient Support Programs Patient Authorization form, 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.

Medicines Available Through This Form

OPSUMIT®* (macitentan) Tablets

OPSYNVI®* (macitentan and tadalafil) Tablets

TRACLEER®* (bosentan) Tablets

UPTRAVI®† (selexipag) Tablets

VELETRI®† (epoprostenol) for Injection

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

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

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

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Johnson & Johnson Patient Assistance Program Patient Enrollment Form (For Pulmonary Hypertension)

The information you provide will be used by Johnson & Johnson Health Care Systems 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*): _____ *Sex: _____

*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
- ☐ **OPSYNVI®** (macitentan and tadalafil) Tablets
- ☐ **TRACLEER®** (bosentan) Tablets
- ☐ **UPTRAVI®** (selexipag) Tablets
- ☐ **VELETRI®** (epoprostenol) for Injection

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.)

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

☐ I have no insurance and have checked eligibility requirements or applied to all available options for free or minimal cost insurance or other assistance.
If you have previously enrolled in a patient assistance program, please provide your patient ID #: _____

Medicare Part D patients only: Medicare ID #: _____

Primary Prescription Insurance (PPI): _____ Card BIN #: _____ Phone: _____

Cardholder Name (*First, MI, Last*): _____ Cardholder Date of Birth: _____

Relationship to Cardholder: _____ Policy #: _____ Group #: _____

Primary Medical Insurance (PMI): _____ Phone: _____

Cardholder Name (*First, MI, Last*): _____ Cardholder Date of Birth: _____

Relationship to Cardholder: _____ Policy #: _____ Group #: _____

Address Line 1: _____ Address Line 2: _____

City: _____ State: _____ ZIP Code: _____

Fax: _____

*Cardholder Employer Name: _____ *Cardholder Employer Phone: _____

*Cardholder Employer Address: _____

*Cardholder Employer City: _____ *Cardholder Employer State: _____ *Cardholder Employer ZIP Code: _____

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

ADP Name: _____ ADP Address: _____

City: _____ ADP State: _____ ADP ZIP Code: _____

Phone: _____ ADP Fax: _____

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I understand that Johnson & Johnson Health Care Systems Inc. (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 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 Johnson & Johnson 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 Johnson & Johnson Patient Assistance 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 as described on this Form.

My "Protected Health Information" includes any and all 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 for the patient support programs, including subcontractors or Healthcare Providers helping Janssen run the programs
- Service providers maintaining, transmitting, de-identifying, aggregating, or analyzing data from Janssen patient support programs

Also, 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, contact me about, and provide services relating to Janssen patient support programs, including in-home services
- 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 Providers regarding access to, reimbursement for and fulfillment of my Janssen medication, and to tell my Healthcare Provider that I am participating in Janssen patient support programs
- Verify, assist with, and coordinate my coverage for my Janssen medication with my Insurers and Healthcare Providers
- 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 Providers
- 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

Janssen and the other data recipients listed on this Form may share information about me as permitted on this Form or if any information that specifically identifies me is removed. I understand that Janssen 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.

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Patient Authorization Form

I understand that 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 or receive assistance from Janssen's patient support programs.

I understand that pharmacies that dispense and ship my medication and service providers for the patient support programs may be paid by Janssen for their services and data. This may include payment for sharing Protected Health Information and other data in connection with these programs, as allowed on this Form.

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 Providers 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 **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:

_____

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Terms & Conditions

JOHNSON & JOHNSON PATIENT ASSISTANCE PROGRAM

You may be eligible to receive your medicine(s) from Johnson & Johnson free of charge for up to one year if you have been prescribed a medicine from J&J, have a financial hardship and have exhausted all other affordability options.

You must meet the eligibility and income requirements to qualify for the Johnson & Johnson Patient Assistance Program.

You are not eligible for free medicine from J&J if your health insurance will cover the cost of your prescribed medicine from J&J if this application is denied. Some employers, insurers, and other companies force patients to apply for medically necessary medicines from free product programs instead of covering such medicines 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 J&J 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 medicines from J&J 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 medicine insurance and treatment. This information will be used by Johnson & Johnson Health Care Systems 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 must spend 4% of your gross annual household income on out-of-pocket prescription costs for yourself and/or other household members. You can provide a report from your pharmacy or an Explanation of Benefits (EOB) statement from your insurer to verify your out-of-pocket expenses for the current year. In addition, if your income is below 150% of the Federal Poverty Level (FPL), you will need to demonstrate that you are not eligible for the Low-Income Subsidy (LIS).

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.

FOR ADMINISTRATIVE PURPOSES ONLY

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