# UPTRAVI® (selexipag) Prescription and Patient Enrollment Form

## FAX COVER SHEET

Date: 2017-01-17

To: ACTELION Pathways Fax number: **1-866-279-0669**

From: _____

Facility name: ZappRx Practice

Facility contact: _____

**Completed UPTRAVI Prescription and Patient Enrollment Form enclosed.**

Number of pages (including cover): _____

Specialty pharmacy preference: ☑ Accredo ☐ CVS/specialty

Comments:

_____

_____

_____

Contact *Actelion Pathways*® at 1-866-ACTELION (1-866-228-3546).



ACTELION

# UPTRAVI® (selexipag) Prescription and Patient Enrollment Form

- **Complete this form for all patients**
- **Fax completed form and copy of patient's insurance card to 1-866-279-0669 and/or include copy of patient demo from electronic medical records**

*EU1201601*

## 1. Patient Information (*please print*)

First name: FirstName MI: _____ Last name: Last1484643319438 Gender: ☐ Female ☑ Male

Birth date: 1945-09-03 Primary language: English Email address: See Attached [3]

Primary phone #: 484-643-3247 Alternate phone #: _____

Address: address1484643323988 City: See [2] State: MA ZIP: 14846

Legal guardian: _____ Relationship: _____ Phone #: _____

## 2. UPTRAVI Tablets Prescription Information

**Please select the following titration dosing order or provide alternate dosing instructions below.**

☐ **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)

Post-titration (highest tolerated) dose: Contact healthcare provider for prescription

**Dosage/Directions:** 200 mcg BID by mouth for 1 week, then increase by 200 mcg BID, at weekly intervals, to the highest tolerated dose up to 1600 mcg BID

**Dispense:** Quantity sufficient for up to maximum allowable dose for up to a 30-day supply

**Titration refills:** 11

**- OR -**

☑ **Alternate dosing instructions:**

See Attached [1]

## 3. Titration Support

**Please select from the following specialty pharmacy titration support services and provide any special instructions, if applicable.**

1. Specialty pharmacy to provide nurse home visit for patient education related to UPTRAVI dosing and titration.
   ☐ Yes ☑ No
2. Specialty pharmacy clinician to assess patient with each dose change until the highest tolerated dose is achieved.
   ☐ Yes ☑ No

**Special instructions (optional):**

_____

_____

_____

_____

## 4. Physician Information (*please print*)

Physician's full name: Lindsay Goldman

Site name: ZappRx Practice

Address: 192 South St City: Boston State: MA ZIP: 02111

Main phone #: 617-555-5555 Fax #: 989-765-5675 NPI #: 6895439888

MD state license number: 666-7654-999

## 5. Physician Signature: Prescription and Statement of Medical Necessity

**I certify that the above therapy ordered is medically necessary and that the information provided is accurate to the best of my knowledge. Further, I hereby authorize *Actelion Pathways*® ("the Hub") to transmit this prescription to the dispensing pharmacy.**

**PHYSICIAN SIGNATURE (REQUIRED TO VALIDATE PRESCRIPTION)**

Physician's signature (dispense as written): _____ Date: _____

Physician's signature (substitution allowed): _____ Date: 01/17/2017

**Physician attests this is his/her legal signature (NO STAMPS). PRESCRIPTIONS MUST BE FAXED.**

The physician 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.

## 6. Diagnosis

**The following ICD-9/ICD-10 codes do not suggest approval, coverage, or reimbursement for specific uses or indications. (Check the box for the appropriate code below.)**

☐ **ICD-9 416.0/ICD-10 I27.0 Primary pulmonary hypertension**

☐ **ICD-9 416.8/ICD-10 I27.2 Other chronic pulmonary heart diseases**

☑ **Other** ICD-9 572.3/ICD-10 K76.6 Portal Hypertension

ACTELION Pathways | **Contact *Actelion Pathways*® at 1-866-ACTELION (866-228-3546)**

## 7. *Actelion Pathways*® Services Authorization

**Authorization to Use and/or Share My Information ("Authorization")**

I authorize my healthcare providers, pharmacies, health plans or payers ("my health care organizations") to share personal and health information about me related to my Actelion PAH therapies ("my information") with Actelion Pharmaceuticals US, Inc., its affiliates, agents and contractors (collectively, "Actelion"). I understand that once my information is shared with Actelion, my information may be protected by certain state privacy laws but not by federal health privacy laws, and may be redisclosed by Actelion. Actelion agrees to protect my information and to use and share it only for the reasons listed below. I understand that my pharmacy may receive compensation in connection with sharing my information with Actelion as allowed under this Authorization.

I authorize my health care organizations to share my information with Actelion, in order for Actelion to: (1) contact me or my healthcare organizations, or others I have identified, about my disease or treatment; (2) confirm my health plan eligibility and benefits, identify other payers for my therapy, or determine whether I may be eligible for assistance programs; (3) enroll me in Actelion PAH therapies-related programs and provide therapy access support services; (4) perform analyses or improve or develop products, services, programs, or treatment, related to my disease; (5) provide me by any means of communication, including by e-mail, mail, or telephone (including voicemail), with information to educate or inform me about Actelion PAH therapies and ways to help me maintain my prescribed treatment; and (6) use and disclose my information for safety reasons or as required by law. I understand that if I do not sign this form, I will still be eligible for health plan benefits and my treatment and payment for my treatment by my healthcare providers and pharmacy will not be affected, but I will not have access to the Actelion services and support described above.

This Authorization will expire 10 years from the date signed below unless a shorter period is required by the law of my state of residence. I may discuss the scope of my Authorization at any time by calling 1-866-875-0277 and may cancel it by writing a letter saying I cancel my Authorization, and mailing it to Actelion Pharmaceuticals US, Inc.: PO Box 826, South San Francisco, CA 94083. My cancellation will not be effective until after Actelion receives it and my health care organizations are notified of it by Actelion, and it will not apply to prior actions taken by Actelion and my health care organizations based on this Authorization. I have a right to request and receive a copy of this Authorization in the same ways described above for cancellation.

Patient name (print): FirstName Last1484643319438

Patient or parent/guardian/representative signature: _____ Date: 01/17/2017

If this form is signed by someone who is not the patient listed, describe the signer's legal authority to act for the patient:

_____



ACTELION

**Patient Name: FirstName Last1484643319438** **Accredo**
**Patient DOB: 09/03/1945** **Uptravi**
**Physician Name: Lindsay Goldman**

**[1] Take  orally  for one week, then increase by 200 mcg at weekly intervals to the highest tolerated dose up to 1600 mcg. Then take 200 - 1600 mcg orally 2 times per day.**

**[2] city1484643324124**

**[3] FirstNameLast1484643319438@zapprx.com**

**Physician Signature** **Date**
**01/17/2017**