FOR VA PATIENTS ONLY

UPTRAVI® (selexipag) Prescription Form

- **Complete this form for all patients and send directly to Accredo specialty pharmacy. Fields marked with a (*) are required.**
- **Accredo Phone: 1-866-344-4874 Fax: 1-800-711-3526**

1. Patient Information *(please print)*

*First name:_____ MI:_____ *Last name_____ Gender: ☐ Female ☐ Male

*Birth date: _____ Primary language: _____ Email address: _____

*Primary phone #:_____ Alternate phone #: _____

*Address: _____ *City:_____ *State: _____ *ZIP: _____

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)

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

- OR -

☐ **Alternate dosing instructions:**

*3. Titration Support

Please select from the following specialty pharmacy titration support services.

1. Specialty pharmacy to provide home visits from nurse for patient education related to UPTRAVI dosing and titration.

   ☐ Yes ☐ No

   If yes, please select <u>one</u> option for home visits:

   ☐ Indicate number of visits ____

   ☐ Until patient's maintenance dose is reached

2. Specialty pharmacy clinician to assess patient with each dose change via telephone until the maintenance dose is achieved.

   ☐ Yes ☐ No

*4. Shipping

Ship to: ☐ Patient home ☐ VA pharmacy

VA pharmacy: _____

Address: _____

City:_____ State: _____ ZIP: _____

Phone #: _____ Fax #: _____

5. Physician Information *(please print)*

*Physician's full name: _____ MD state license #:_____

Site name: _____

*Address:_____ *City:_____ *State:_____ *ZIP: _____

*Main phone #: _____ Fax #:_____ NPI #: _____

*6. Physician Signature

I have made the determination, based on my independent clinical judgment, that the medication ordered is medically necessary for the patient for the intended use. I am personally supervising the care of this patient. I certify that the requested additional titration support is necessary beyond the support my office has already provided. I authorize Actelion Pharmaceuticals US, Inc., its affiliates, agents, and contractors (collectively, "Actelion") to act on my behalf for the limited purposes of transmitting this prescription to the appropriate pharmacy designated by the patient utilizing their benefit plan. This authorization includes permitting Actelion to communicate to payers on my behalf to confirm this patient's health plan eligibility and benefits. **PHYSICIAN SIGNATURE REQUIRED TO VALIDATE PRESCRIPTIONS. Physician attests this is his/her legal signature (NO STAMPS). Prescriptions must be faxed.**

Physician signature: _____ Physician signature: _____ Date:_____

Dispense as Written Substitution Allowed

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.

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