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Patient Information	First name:		MI:	Last name:		Gender: Male Female	
	SSN:			DOB:		Primary language:	
	E-mail address:		Phone #:		Alternate Phone #:		Best time to call:
	Address:			City:		State:	ZIP:
	Legal guardian/emergency contact:			Relationship:		Phone #:	
	Shipping directions: Physician office Patient's home			Shipping attn:			
	Shipping address:			City:		State:	ZIP:

Insurance Information	Insurance Company (Primary or Prescription Coverage):		Phone #:
	Name of insured:	Policy #:	Group/Policy #:
	Indicate specialty pharmacy preference:		

Patient/guardian signature: _____ Date: _____

First name:	MI:	Last name:	E-mail Address:		Degree:
DEA #:	NPI #:	Tax ID #:	State license #:		
Complete section below only if you are a new prescriber or your contact information has changed.					
Facility name:		Affiliated hospital:		Specialty:	
Office contact:		E-mail Address:		Phone #:	Fax #:
Primary address:	City:	State:	ZIP:	Preferred method of contact: <div style="text-align: right; font-size: small;"> <input type="checkbox"/> Phone <input type="checkbox"/> Fax <input type="checkbox"/> E-mail </div>	
DIAGNOSIS (CHECK Only One Box for the Diagnosis Related to Tracleer Treatment): ICD 416.0 – Pulmonary Arterial Hypertension (PAH) OR ICD 416.8 – Pulmonary Arterial Hypertension Idiopathic PAH Familial PAH Connective tissue disease Congenital heart disease Other _____					
BEFORE SIGNING, SEE IMPORTANT SAFETY INFORMATION ON BACK. REQUIRED: Please complete all sections below: 1. You have reviewed liver function tests. Yes No 2. Patient is a female of childbearing potential? Yes No 3. If #2 is yes, you have confirmed a negative pregnancy test. Yes No 4. Is patient currently in an inpatient facility? Yes No 5. Directions for Use and Dispensing Instructions: Complete A or B below A. Sig: Take 62.5 mg tablet by mouth twice daily x 4 weeks, then increase to the maintenance dose of 125 mg tablet by mouth twice daily. Disp: Tracleer 62.5 mg tablets (66215-0101-06) (60 tablets). No refills. Tracleer 125 mg tablets (66215-0102-06) (60 tablets). Refill x 11. OR B. Sig: _____ _____ (Qty) tablets Disp: Tracleer 62.5 mg tablets (66215-0101-06) _____ (Qty) tablets Tracleer 125 mg tablets (66215-0102-06) _____ (Qty) tablets 6. By signing, I certify that the above therapy is medically necessary. If shipped to prescriber's office, prescriber accepts on behalf of patient.			Prescriber Certification: Complete this section only if you are not currently a certified prescriber. My signature below certifies that: 1. I have read and understood the communication and educational materials for prescribers regarding the risks of Tracleer, and agree to document that I: – Reviewed and discussed the Medication Guide and the risks of Tracleer (including the risks of teratogenicity and hepatotoxicity) with my patients prior to prescribing Tracleer. – Reviewed liver function tests (ALT/AST/bilirubin) and confirmed that my patients are not pregnant (if applicable), and I agree to order and monitor monthly liver function tests and, if applicable, pregnancy tests. – Educated and counseled females of childbearing potential (see definition on reverse side) to notify me if they suspect they may be pregnant. – Educated and counseled females of childbearing potential about the need to use reliable methods of contraception (see table on reverse side) during treatment with Tracleer and for one month after treatment discontinuation. 2. I will notify Actelion Pharmaceuticals US, Inc., and/or the FDA, of any adverse events, including hepatotoxicity, and report any pregnancy during treatment with Tracleer. 3. I will counsel my patients who fail to comply with the program requirements. 4. I will renew my patients' T.A.P. enrollment annually by completing and submitting a new form for patients continuing therapy.		
Prescriber attestation: _____ Date: _____			Prescriber signature: _____ Date: _____		

Tracleer® (bosentan) Enrollment for Patients and Prescribers

PO Box 826, South San Francisco, CA 94083-0826 • Phone 1-866-ACTELION (1-866-228-3546) or Fax 1-866-279-0669

Patient Agreement

- I have reviewed the Medication Guide with my healthcare provider. I understand that a Medication Guide will be provided to me each time I receive a prescription for Tracleer, and that I must read it each time because it may have new information important to my treatment.
- I have been informed of the risks of treatment with Tracleer, including the risks of liver damage and birth defects. I understand that I will be contacted by Actelion, its agents, and/or a healthcare provider to receive counseling on the risks of Tracleer treatment, to ensure that I am completing the required liver function tests and pregnancy tests (for females of childbearing potential—see definition below) and, if I am a female who becomes pregnant, to obtain information about my pregnancy.
- I agree to notify Actelion or my specialty pharmacy if I should change prescribers.
- I agree to have monthly blood tests as ordered by my healthcare provider for as long as I take Tracleer.
- I authorize my healthcare providers, health plans, other payers, and pharmacies to disclose my personal, medical, and health information to Actelion Pharmaceuticals US, Inc., and its employees, distributors, agents, and contractors ("Actelion"), and I authorize Actelion to use and disclose this information for use in implementing T.A.P. including to: 1) establish my benefit eligibility; 2) communicate with my healthcare providers, health plans, other payers, and pharmacies about my medical care; 3) provide support services, including facilitating the provision of Tracleer to me; and 4) help find ways to pay for Tracleer, or for treatment or healthcare operations in progress.
- I understand that Actelion cannot guarantee that it will be able to find ways to pay for my Tracleer, and I know that I am responsible for the costs of my care.
- I understand that I may be contacted by Actelion or its delegates regarding important safety surveys while I am taking Tracleer.
- I understand that once my health information has been disclosed to Actelion, privacy laws may no longer restrict its use or disclosure; however, Actelion agrees to protect my information by using and disclosing it only for the purposes described above or as required by law.
- I acknowledge and agree that, although Actelion will have access to my personal health information, Actelion will not be providing counseling or medical advice regarding my condition. I further understand that all questions regarding my medical and health conditions should be discussed with my healthcare provider.
- I consent to be in the Tracleer Access Program for as long as I am taking Tracleer.

Definition of Female of Childbearing Potential (FCBP)

Female patients who are physically capable of becoming pregnant include those who are pubertal and have not yet had menses (premenarchal, Tanner stage 3, 11.5 to 13 years of age), perimenopausal and have had spontaneous menses in the last 24 months, and nonmenopausal who have not had a hysterectomy, bilateral oophorectomy, or medically documented ovarian failure.

Female patients who are not considered to be of childbearing potential are surgically sterile (both ovaries and/or uterus removed), postmenopausal (no menstrual period for longer than 24 consecutive months, confirmed by their healthcare provider), or incapable of pregnancy (confirmed by their healthcare provider).

Reliable methods of contraception during treatment with Tracleer

Methods to use alone	Hormone (choose 1 and use with a barrier method)	Barrier (use both OR choose 1 and use with a hormone method)
<ul style="list-style-type: none">• Intrauterine devices (IUDs)<ul style="list-style-type: none">—Copper T 380A IUD—LNg-20 IUS (progesterone IUD)• Tubal sterilization	<ul style="list-style-type: none">• Estrogen and progesterone<ul style="list-style-type: none">—Oral contraceptives—Transdermal patch—Vaginal ring• Progesterone only<ul style="list-style-type: none">—Injection—Implant	<ul style="list-style-type: none">• Male condom with spermicide• Diaphragm with spermicide OR Cervical cap with spermicide
A partner's vasectomy still requires 1 additional method of contraception.		

Authorization for Use or Disclosure of Health Information

Fax To: 1-866-279-0669

Patient Name: _____ Date of Birth: _____

I have elected to participate in the following program(s):

Sure Steps™ is a patient support and educational program for patients with pulmonary arterial hypertension who are on Actelion PAH therapies.

LabTrac™ is a program designed to assist your physician in managing your care. LabTrac allows your physician to centrally review all of your laboratory results associated with your treatment on Tracleer.

By signing below, I authorize Actelion Pharmaceuticals US, Inc., and agents operating the above-described Programs (collectively, "Actelion") to use and disclose any and all of my individually identifiable health information, including, but not limited to, any and all spoken or written facts about my health, medications, insurance benefits, and all records maintained by Actelion in connection with the Programs ("Health Information"), as described in this authorization.

I agree that Actelion may use and disclose my Health Information to Program representatives and third parties that work with Actelion (the "Authorized Persons") in order for the Authorized Persons to provide me with marketing, promotional or educational information with respect to the Programs, PAH, related conditions and/or treatment options (the "Information"). I agree that I may be contacted by the Authorized Persons by phone, mail, e-mail or through other means with respect to the Information. I understand that Actelion does not sell my Health Information to the Authorized Persons but that the Authorized Persons may receive remuneration from Actelion in connection with their involvement with the Programs, including the dissemination of the Information.

I understand and agree that the Authorized Persons may use and see my Health Information for the purposes described above. I understand that my Health Information may also be disclosed as needed to deal with safety, my treatment, adverse events, and related issues to the extent allowed under applicable law or as previously consented to in writing by me. I understand that if my Health Information is disclosed as allowed in this authorization, it may be redisclosed by the Authorized Persons and such redisclosure may not be protected by federal and state privacy laws.

This authorization expires ten (10) years from the date I sign this document. If I change my mind before that time and do not want Actelion to continue to share my Health Information in connection with the above-referenced Programs, I can notify Actelion of such revocation in writing, signed by me or my personal representative on my behalf and delivered to PAH Pathways c/o Actelion at 5000 Shoreline Court, Suite 200, South San Francisco, CA 94080. If I notify Actelion in writing to stop sharing my Health Information in connection with the above-referenced Programs, such notice will be effective upon receipt by Actelion but will not change any actions that Actelion or others took in reliance upon this authorization before my effective revocation of this authorization.

I know that I may refuse to sign this authorization. My decision not to sign this authorization or to, at any time, revoke this authorization will not affect my ability to get treatment from my healthcare providers, or to seek payment or eligibility for benefits.

I understand that I have a right to receive a copy of this authorization. **I agree that a copy of this authorization may be treated as a signed original.**

Patient signature: _____ **Date:** _____

Personal Representatives Section: If this form is signed by someone who is not the participant listed at the top of this authorization, describe the signer's legal authority to act for the participant: