**PRIOR AUTHORIZATION PROGRAM REIMBURSEMENT REQUEST FORM**
For pulmonary hypertension therapy: Uptravi (selexipag)

Please note that the patient AND physician must complete this form. **All fields are mandatory and must be completed. Incomplete forms may result in your application being declined.** Please retain a copy of this form for your records.

**Instructions:**
1. **PLEASE PRINT CLEARLY AND COMPLETE ALL SECTIONS.**
2. The patient/plan member must complete section A.
3. Your physician must complete section B. The cost, if any, of completing this form is at the expense of the patient/plan member.
4. Please return the form to your insurance company via Pharmacy Services at TELUS Health (a service provider of your insurance company) by fax to 1-866-840-1509, OR mail to TELUS Health, 4141 Dixie Rd. P.O. Box 41154, Mississauga, Ont. L4W 5C9.
5. If you have any questions on the application of this program or the decision on reimbursement, or to inquire on the status of your Reimbursement Request Form, please contact your insurer.

### A. Information to be Completed by Patient

<table>
<thead>
<tr>
<th>Employee or Insured’s Name</th>
<th>Drug Card Number</th>
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<table>
<thead>
<tr>
<th>Patient’s Name</th>
<th>Patient’s Date of Birth (DD/MMM/YYYY)</th>
<th>Relationship to Employee/Insured</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Employee  Spouse  Dependent</td>
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</tbody>
</table>

Please allow two business days for a response once all information is received and complete. Notification of the results of this request will occur Monday to Friday between 9 am and 4 pm Eastern Time.

Please provide contact information and indicate **ONE** method of preferred contact for notification of the results:

- [ ] E-mail me at: ...
- [ ] Call me (and leave a message if I’m not there) at: ...
- [ ] Fax me at: ...
- [ ] Contact my pharmacy:
    - Pharmacy Name: ...
    - Pharmacy Phone Number: ...

I certify that the information provided by me is true, correct and complete to the best of my knowledge. I authorize my insurance company, TELUS Health (a service provider of my insurance company), their authorized representatives, agents and service providers to use and exchange this information needed for underwriting, administration and paying claims with any person or organization who has relevant information pertaining to this claim including health professionals, institutions and investigative agencies in the event of an audit. I authorize my insurance company and/or TELUS Health (a service provider of my insurance company) to contact any licensed physician, institution, pharmacy or person who has any records or knowledge of me or my health with respect to this submitted claim.

**SIGNATURE OF PATIENT/PARENT/LEGAL GUARDIAN**

Date: (DD/MMM/YYYY): __ / __ __ __ / __ __ __

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The most current version of this form supersedes all prior versions. The form may be modified without notice to you and we reserve the right to accept only the current version. **Revised March 2017. UPTRAVI-1703**
**B. Information to be Completed by Prescribing Physician**

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Strength</th>
<th>Dose</th>
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<tbody>
<tr>
<td>Upravi (selexipag)</td>
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Upravi (selexipag) will be eligible for reimbursement only if the patient satisfies the conditions listed below and if the patient does not qualify for coverage under any other drug plan or government mandated program. If the patient is covered under another drug plan or government mandated program, the prior authorization program, as part of your drug benefits, may cover the portion not paid for by the primary plan. If “None of the above criteria” is indicated, the patient will not be eligible for reimbursement. **For Quebec plan members, please refer to the RAMQ exception drug criteria, if applicable.**

### Eligibility Criteria

Please indicate if the patient satisfies ALL of the following criteria:

**Initial Criteria (3 months duration):**
- ☐ Patient has a diagnosis of pulmonary arterial hypertension (PAH)
- ☐ PAH WHO functional class (FC) II-III
- ☐ Patient is ≥18 years old
- ☐ The prescribing physician is a cardiologist or a pulmonologist or experienced in the treatment of PAH
- ☐ Patient does not have severe hepatic impairment (Child-Pugh class C)
- ☐ Patient is not undergoing renal dialysis

**Renewal Criteria (1 year):**
- ☐ The patient meets the initial criteria
- ☐ The patient did not experience disease progression, indicated by at least one of the following:
  - ☐ Hospitalization for PAH
  - ☐ Decrease in 6-minute walk distance [6MWD] from baseline (≥ 15%)
  - ☐ Need for additional PAH- specific therapy

OR

- ☐ None of the above criteria applies.

Relevant additional information________________________________________

### Physician Information

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<th>Physician’s Name</th>
<th>License Number</th>
<th>Telephone Number</th>
<th>Fax Number</th>
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<tr>
<th>Physician’s Signature</th>
<th>Date: (DD/MMM/YYYY)</th>
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