OJJAARA Dose Modification Program

Ojjaara (momelotinib) 200 mg • 150 mg • 100 mg tablets

CONTACT INFORMATION

Phone: (502) 212-1143 | Fax: (502) 212-1109 | Email Address: ojjaaradm@pharmacord.com

ENROLLMENT FORM

The OJJAARA Dose Modification Program is available for patients who require mid-cycle dose adjustments of their current tablet strength. A 30-count bottle of OJJAARA will be provided to your patient at no cost.

INSTRUCTIONS FOR PRESCRIBER

Complete
Review and complete this entire form

Sign
Prescriber must sign and date at the bottom of **section 4**

Fax
Fax this entire form to: (502) 212-1109

ELIGIBILITY REQUIREMENTS

To be eligible for the OJJAARA Dose Modification Program, a patient must:

- Be a legal resident of the United States (including Washington DC, Puerto Rico, US Virgin Islands, or US territories)
- Be prescribed OJJAARA for a US Food and Drug Administration (FDA)-approved indication
- Have remaining pills from a current prescription for an FDA-approved indication
- Not have already had 2 separate dose reductions from the OJJAARA Dose Modification Program
- Not be receiving OJJAARA from the Patient Assistance Program

The program is available to all patients who meet eligibility requirements, including those enrolled in Medicare or other government-funded programs.

Please note: To provide your patient a reduced dose of OJJAARA at no charge, this program is dispensed by PharmaCord Pharmacy rather than your in-office dispensary or the specialty pharmacy that is currently dispensing your patient's prescription. OJJAARA can be shipped to the patient as early as 24 hours after the receipt of this form, if the completed form is received before 3 PM ET.

For ongoing refills, a new prescription will need to be submitted to the patient's existing specialty or in-office dispensing pharmacy. We will contact your office after your patient's dose has been shipped so that you may adjust the next month's prescription as needed.

Future prescriptions are not required to participate in the OJJAARA Dose Modification Program.

SECTION 1. PATIENT INFORMATION

Name: _____ DOB (mm/dd/yyyy): _____ Phone: _____

Address: _____

Email: _____ Best time to contact: _____

Alternative Contact Name: _____ Phone: _____

SECTION 2. PRESCRIBER INFORMATION

Name: _____ Practice: _____

Address: _____

Office Contact: _____ Preferred method of contact: ❍ Phone ❍ Fax ❍ Email

Phone: _____ Fax: _____ Email: _____

NPI#: _____ State License #: _____ Tax ID#: _____ DEA#: _____

OJJAARA Dose Modification Program

Ojjaara (momelotinib) 200 mg • 150 mg • 100 mg tablets

Patient Name:_____ Patient DOB: MM / DD / YYYY

SECTION 3. PRESCRIPTION INFORMATION

Provider Name: _____ Provider NPI: _____ Provider Phone: _____

DOSE MODIFICATION PROGRAM

Current Prescription Dose (Select only 1)

❍ OJJAARA 150-mg tablets PO QD #30

❍ OJJAARA 200-mg tablets PO QD #30

New Prescription Dose (Select only 1)

❍ OJJAARA 100-mg tablets PO QD #30

❍ OJJAARA 150-mg tablets PO QD #30

Diagnosis Code: _____

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute

Prescriber's Signature:_____ SIGNATURE HERE

Date: MM / DD / YYYY

May Substitute / Product Selection Permitted / Substitution Permissible

Prescriber's Signature:_____ SIGNATURE HERE

Date: MM / DD / YYYY

Special Note: If a New York prescriber, please use an original New York State prescription form. The prescriber is to comply with the prescriber's state-specific prescription requirements.

Known Drug Allergies:_____

Current Medications:_____

Please Note: For ongoing refills, a new prescription will need to be submitted to the patient's existing specialty or in-office dispensing pharmacy. Future prescriptions are not required to participate in the OJJAARA Dose Modification Program.

SECTION 4. TERMS AND CONDITIONS

- The OJJAARA Dose Modification Program is available at no charge to any patient prescribed OJJAARA for an FDA-approved indication
- Patients who are reducing doses must not have already had two (2) separate dose reductions under the OJJAARA Dose Modification Program
- No one participating in the program may bill or seek payment or reimbursement for tablets received from the program from any third-party payer, including any state or federal entity or any private or other insurance plan
- Those prohibited from billing or seeking payment or reimbursement for tablets received from the program include patients, prescribers, institutions, pharmacies, pharmacists, or any other person or prescriber
- Medicare Part D patients who participate in the Program must agree that no part of the costs of the drug provided as part of the Program shall be counted towards their out-of-pocket costs, and no claim will be filed with a Part D plan for drug supplied by the Program
- Product provided pursuant to this OJJAARA Dose Modification Progam may not be sold, traded, or distributed for sale
- GSK reserves the right to change or end the program at any time without notice

Prescriber: I certify that I understand and agree: 1) That I have explained to my patient the Terms and Conditions of the OJJAARA Dose Modification Program; 2) I am licensed to prescribe the prescription medication identified in this form; (3) The prescription complies with my state-specific prescribing requirements; 4) In my medical judgment, the new dose of OJJAARA is clinically appropriate for the patient named above and its use is consistent with the FDA-approved indication; and 5) This supply of OJJAARA is specifically for the patient named above.

PRESCRIBER'S SIGNATURE _____ NO STAMPS PLEASE Date: MM / DD / YYYY