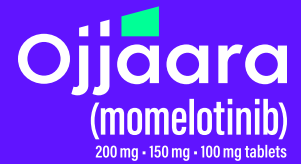


# OJJAARA Dose Modification Program



## CONTACT INFORMATION

Phone: (502) 212-1143 | Fax: (502) 212-1109 | Email Address: [ojjaaradm@pharmacord.com](mailto: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: \_\_\_\_\_

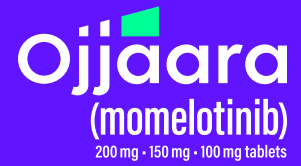
Address: \_\_\_\_\_

Office Contact: \_\_\_\_\_ Preferred method of contact:  Phone  Fax  Email

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

NPI#: \_\_\_\_\_ State License #: \_\_\_\_\_ Tax ID#: \_\_\_\_\_ DEA#: \_\_\_\_\_

# OJJAARA Dose Modification Program



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 Program 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

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