## United Therapeutics TYVASO® (treprostinil) and TYVASO DPI® (treprostinil) VA Referral Form

Prescriber: Please forward this completed form to the VA Pharmacy. The VA Pharmacy will fax the completed form to Accredo at Fax: 1-800-711-3526, Phone: 1-866-344-4874 or CVS Specialty at Fax: 1-877-943-1000, Phone: 1-877-242-2738.



| STEP 1 PATIENT INFORMAT                        | TION                               |  |
|--|------------------------------------|--|
| Name: First                                    | Middle                             | Last   |
| Date of Birth                                  | Sex                                | Preferred Language                           |
| Home Address                                   |                                    |  |
| City   | State                              | Zip  |
| Shipping Address (if different from home addre | ss)                                |  |
| City   | State                              | Zip  |
| Telephone Home Cell Work                       | Alternate Telephone Home Cell Work |  |
| E-mail Address                                 |                                    | Morning Afternoon Evening Anytime            |
| Caregiver/Family Member                        | Caregiver Telephone Home Cell Work | Caregiver Alternate Telephone Home Cell Work |
| Caregiver E-mail Address                       | Caregiver Alternate E-mail Address |  |

## **VA PHARMACY INFORMATION STEP** 2

| Name of VA Facility                 |                            |                  |        |                     |  |
|-------------------------------------|----------------------------|------------------|--------|---------------------|--|
| Address                             | Suite City                 |                  | State  | Zip                 |  |
| Primary Purchasing Contact Name     | Telephone                  | Fax              | E-mail |                     |  |
| Primary Clinical Contact Name       | Telephone                  | Fax              | E-mail |                     |  |
| Secondary Purchasing Contact Name   | Telephone                  | Fax              | E-mail |                     |  |
| Secondary Clinical Contact Name     | Telephone                  | Fax              | E-mail |                     |  |
| Payment Method                      |                            | Purchase Order # |        | Ship to             |  |
| Credit Card (call pharmacy contact) | E-invoice Tungsten Network |                  |        | Patient VA Location |  |

| STEP 3 PRESCRIBER INFOR                | MATION          |  |
|--|-----------------|--|
| Prescriber: First                      | Last            |  |
| NPI#                                   | State License # |  |
| Facility Name                          | MD Specialty    |  |
| Address                                |                 |  |
| City                                   | State           | Zip  |
| Office Contact Name                    | Telephone       | Fax  |
| E-mail Address                         |                 | Preferred Method of Communication<br>Phone E-mail Mail Fax |
| PCP (if different from prescribing MD) | PCP Phone       |  |



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| _                  | PH-ILD - USE THIS SECTION FOR   |                               |                             |                          |  |                         |                           |
|--------------------|---|-------------------------------|-----------------------------|--------------------------|--|-------------------------|---------------------------|
|                    | luct Therapy Status for the Requested Dr  | -                             | Specialty Pharmacy:         |                          | Patient Status                           |                         | WHO Group:                |
| Na                 | aïve/New Restart Transition   | Accre                         | do Health Group, Inc.       | CVS Specialty            | Outpatient                               | Inpatient               |                           |
| eight:             | kg lb <b>Height:</b> ftin   | Diabetic:                     | Allergies:                  |                          |  |                         |                           |
| <b>j</b>           |   | Yes No                        | Drug Allergies              | Non-Drug Allerg          | es No Known Al                           | ergies                  |                           |
|                    |   |                               |                             |                          |  |                         |                           |
|                    | TYVASO (treprostinil) 1.74mg/2.9ml  | ampule (0.6mg/                | (ml) Inhalation Solution    | on                       |  | Dose Co                 | mparison                  |
|                    | Target dose: 9 breaths (54 mcg) to 12 br  |                               | •                           |                          | · · ·                                    | and the                 |                           |
| 3                  | (if 3 breaths are not tolerated, use 1 to 2 breat   |                               | additional 1 breath per wee | ek, if tolerated, ur     | itil the target                          |                         |                           |
|                    | dose of 9 breaths (54 mcg) to 12 breaths (72 r<br>TYVASO Inhalation System Starter Kit (2   |                               | efills                      |                          |  | TYVASO                  | TYVASO DPI                |
|                    | TYVASO Inhalation System Refill Kit (28   |                               | Nebulizer                   | Cartridge                |  |                         |                           |
|                    | The medication cost does not include the ne   |                               |                             | ided at an additi        | onal charge.                             | # of Breaths            | Strength                  |
|                    | Prescriber may specify any alternative  |                               |                             |                          |  | ≤5                      | 16 mcg                    |
|                    | resense may specify any aternative  |                               | only and thration mat       |                          | · · · · ·                                | 6 to 7                  | 32 mcg                    |
|                    | OR  |                               |                             |                          |  | 0107                    |                           |
|                    | TYVASO DPI (treprostinil) Inhalation  |                               |                             |                          |  | 8 to 10                 | 48 mcg                    |
|                    | Target dose: 48 mcg or 64 mcg or Other mcg per treatment session, 4 times daily (Check One)   Start with one 16-mcg cartridge per treatment session, 4 times daily. Increase cartridge strength by 16 mcg per treatment 11 to |                               |                             |                          |  |                         |                           |
|                    | session every week to selected target dose. Tit   |                               |                             |                          |  |                         | 4                         |
|                    | than 64 mcg per treatment session, more than  |                               |                             |                          | J. J |                         |                           |
|                    | TYVASO DPI Titration Kit (28-day supply)  | Choose one for tit            | ration phase.               |                          |  |                         |                           |
|                    | 16 mcg (112 ct), 32 mcg (112 ct), and 48 mcg  |                               | <b>6</b> 11                 |                          |  |                         |                           |
|                    | TYVASO DPI Maintenance Kit (28-day supp   |                               |                             | aa lait faa tha daa      | ined to make do no                       |                         |                           |
|                    | Inhale one breath per cartridge, 4 times da   | -                             |                             | ce kit for the des       | sired target dose.                       |                         |                           |
|                    |   |                               | I mcg (112 ct)              |                          |  |                         |                           |
|                    | Prescriber may specify any alternative or<br>treatment session, more than 1 cartridge   |                               | -                           | ns here. If the p        | prescribed dose is h                     | igher than 64 i         | mcg per                   |
|                    |   | ••••••                        |                             |                          |  |                         |                           |
|                    | Specialty Pharmacy to contact prescribing practitioner for adjustmen  | ts to the written orders spec | ified above.                |                          |  |                         |                           |
| URSING (           | ORDERS  |                               |                             |                          |  |                         |                           |
| URSING             | ORDERS  |                               |                             |                          |  |                         |                           |
|                    | ck this box if you would like your patient to re<br>atients who are learning to administer their Ty   |                               | prted* patient education f  | for Tyvaso and/c         | r Tyvaso DPI admini                      | stration. Nurse         | support* is               |
| ote: Order fo      | r this drug is not inclusive of skilled nursing ho  | me health service             | s. To request skilled nursi | ing services for l       | nome inhalation ther                     | apy, the referri        | ng VA                     |
|                    | Id enter a COMMUNITY CARE-GEC SKILLED F   |                               | •                           | nity care office v       | vill coordinate the re                   | quested service         | e through CCN             |
| ,                  | Care Network) or VCA (Veteran Care Agreeme  | , ,, ,                        |                             | estion and/or th         | air diagaga. It is into                  | ndad ta aunala          | monto                     |
| ••                 | rt is limited to education for patients and thei<br>erstanding of their therapy, and is not intende   | •                             |                             |                          |  | ••                      |                           |
|                    | services, or serve as a reason to prescribe. P  | •                             |                             |                          |  |                         | -,                        |
|                    |   |                               |                             |                          |  |                         |                           |
| TEP 4              | PRESCRIBER SIGNATURE: PRES  | CRIPTION AN                   | ND STATEMENT OF             | MEDICAL N                | ECESSITY                                 |                         |                           |
|                    |   |                               |                             |                          |  |                         | anno of the state         |
|                    | iy that the pulmonary hypertension associated with in<br>SICIAN'S SIGNATURE REQUIRED TO VAL   |                               |                             | ledically necessary      | and that I am personal                   | y supervising the       | care of this patie        |
|                    | ian's Signature:  |                               |                             |                          |  | Date:                   |                           |
| Physic             | Dispense as Wr  | ritten                        | Sub                         | ostitution Allowed       |  |                         |                           |
| Physic             | Specific Dispense as Written (DAW) Selection Ver  | biage:                        |                             |                          |  |                         | · · · · · · · · · · · · · |
|                    | ,   |                               |                             |                          |  |                         |                           |
| State-s<br>(Physic | cian attests this is his/her legal signature. NO STA<br>nd Tyvaso DPI are registered trademarks of United Therapeutics Corpo  |                               |                             | The makers of these bron | ds are not affiliated with and do        | not endorse I Inited Th | eraneutics or its produ   |

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| TEP (5)      | PAH - USE   | THIS SECT  | TION FOR PAH  |  |  |                      |  |                                     |
|--------------|---|--|---|--|--|----------------------|--|-------------------------------------|
|              | l <b>uct Therapy S</b><br>aïve/New                      | Status for the<br>Restart  | e <b>Requested Drug:</b><br>Transition  | -  | ecialty Pharmacy<br>Health Group, Inc.                       |                      | Patient Status:<br>Outpatient Inpatie                        | WHO Grou                            |
|              | ional Class:  |  | Walaha  | line lle   | Diabetic:  | Allergies:           |  |                                     |
| I            | II III  | IV   | Weight:ft   |  | Yes No   | Drug Allerg          | gies Non-Drug Allergies                                      | No Known Allerg                     |
|              | Target dose<br>(if 3 breaths<br>dose of 9 bre<br>TYVASO | e: 9 breaths (5<br>are not tolerate<br>aths (54 mcg) f<br>Inhalation Sys | <b>1.74mg/2.9ml ampu</b><br><b>54 mcg) to 12 breaths</b><br>d, use 1 to 2 breaths). In<br>to 12 breaths (72 mcg), <i>4</i><br>tem Starter Kit (28-day<br>tem Refill Kit (28-day s | (72 mcg), 4 tin<br>crease by an add<br>times daily.<br>supply) 0 refills | <b>nes daily</b> - Start with<br>litional 3 breaths per<br>s | n 3 breaths (18 mcg  | ) 4 times daily<br>until the target                          | vvaso<br>bulizer<br>Cose Comparison |
|              |   |  | not include the nebulize  |  |  | ovided at an addit   |  | Breaths Strength                    |
|              | Prescriber  | may specify  | any alternative or ad   | ditional dosin   | g and titration in   | structions here      |  | ≤5 16 mcg                           |
|              | OR  |  |   |  |  |                      |  | 6 to 7 32 mcg                       |
|              |   |  | nil) Inhalation Powd  |  |  |                      |  | 8 to 10 48 mcg                      |
|              | Start with one  | e 16-mcg cartri  | or 64 mcg or Other<br>dge per treatment session<br>red target dose. Titration   | n, 4 times daily. I  | ncrease cartridge stre                                       | ength by 16 mcg pe   | r treatment  | 1 to 12 64 mcg                      |
|              | treatment s   | nay specify an<br>ession, more   | cg (112 ct) 48 mcg (1<br>ny alternative or addit<br>than 1 cartridge will b<br>practitioner for adjustments to the w  | ional dosing an<br>ne needed per s                                       | ession:  | ions here. If the p  | prescribed dose is higher t                                  | han 64 mcg per                      |
| URSING       | ORDERS  |  |   |  |  |                      |  |                                     |
| Please che   | ck this box if yo                                       |  | your patient to receive<br>dminister their Tyvaso   |  | d* patient educatio  | n for Tyvaso and/o   | or Tyvaso DPI administratio                                  | n. Nurse support* is                |
| ovider shou  | ld enter a COM  | MUNITY CAR   |   | CARE consult. T  |  |                      | home inhalation therapy, th<br>will coordinate the requeste  |                                     |
| tient's unde | erstanding of th  | eir therapy, a   | •   | rovide medical a   | advice, replace a tre  | , ,                  | eir disease. It is intended t<br>the patient's doctor or nur | ••                                  |
| TEP 5        | PRESCRIE  | BER SIGNA  | TURE: PRESCRIF  | TION AND   | STATEMENT O  | F MEDICAL N          | IECESSITY  |                                     |
|              |   | -  | hypertension therapy or<br>QUIRED TO VALIDAT  |  |  | and that I am perso  | nally supervising the care of                                | this patient.                       |
|              |   |  |   |  |  |                      | Date:  |                                     |
| рнүз         | ian's Signature:  |  | Dispense as Written   |  |  | Substitution Allower | 1  |                                     |
| PHYS         |   |  | Dispense as Written<br>AW) Selection Verbiage:  |  | s  | Substitution Allowed |  |                                     |

