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

Tyvaso and Tyvaso DPI are available through select specialty pharmacy (SP) providers.

TYVASO DPI (treprostinii) NAMATON TYVASO

PRESCRIBER:

STEP

Name: First

1

• Send the VA Pharmacy the completed enrollment form and the fax cover sheet. The VA Pharmacy will forward these on to the SP.

PATIENT INFORMATION

• Complete all sections on this form. Let your patient know that the SP will be calling to process their prescription and that it is important to answer or return any messages.

Middle

• Sign at the bottom of page 2 or 3.

VA PHARMACY:

Last

- Review VA Pharmacy information to ensure it's complete and correct.
- Fax documents to the selected SP using the fax cover sheet provided.

Date of Birth	Sex	Preferred Language
Address Suite	e City	State Zip
Shipping Address (if different from home address) Suite	e City	State Zip
Telephone Home Cell Work	Alternate Telephone Home Cell Work	Best Time to Call
E-mail Address	Caregiver/Family Member	Morning Afternoon Evening Anytime
Caregiver Telephone Home Cell Work	Caregiver Alternate Telephone Home Cell Wo	rk Caregiver E-mail Address
STEP 2 VA PHARMACY INFORMAT	TON	
STEP 2 VA PHARMACY INFORMAT Name of VA Facility	ION	
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 Tung	gsten Network	Patient VA Location
STEP 3 PRESCRIBER INFORMATION	ON	
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
PCP (if different from prescribing MD)	PCP Phone	_ Phone E-mail Mail Fax



Patient Na	ame:		Date of Birth:			
STEP 4	PH-ILD - USE THIS SECTION FOR	R PH-ILD				
	duct Therapy Status for the Requested D laïve/New Restart Transition		Specialty Pharmacy: do Health Group, Inc. CVS Specialty	Patient Status: Outpatient	Inpatient	WHO Group:
Weight:	kg lb Height: ftin	Diabetic: Yes No	Allergies: Drug Allergies Non-Drug Allerg	ies No Known All	lergies	
	TYVASO (treprostinil) 1.74mg/2.9ml Target dose: 9 breaths (54 mcg) to 12 b (if 3 breaths are not tolerated, use 1 to 2 breaths (54 mcg) to 12 breaths (72 TYVASO Inhalation System Starter Kit (TYVASO Inhalation System Refill Kit (2): The medication cost does not include the r Prescriber may specify any alternative OR TYVASO DPI (treprostinil) Inhalation Target dose: 48 mcg or 64 mcg or Start with one 16-mcg cartridge per treatment session every week to selected target dose. Than 64 mcg per treatment session, more than TYVASO DPI Titration Kit (28-day supply) 16 mcg (112 ct), 32 mcg (112 ct), and 48 mcg TYVASO DPI Maintenance Kit (28-day supply) Inhale one breath per cartridge, 4 times of 16 mcg (112 ct) 32 mcg (112 ct) 48 Prescriber may specify any alternative of treatment session, more than 1 cartridge.	reaths (72 mcg), 4 aths). Increase by an mcg), 4 times daily. (28-day supply) 0 re 8-day supply) X nebulizer device and e or additional do 1 Powder Other m 1t session, 4 times dail itiration schedule may in 1 cartridge will be re 10 Choose one for titration of the complex of the c	times daily - Start with 3 breaths (18 mcg additional 1 breath per week, if tolerated, unefills refills	ional charge. (Check One) Ir treatment dose is higher sired target dose.	TYVASO Nebulizer # of Breaths ≤5 6 to 7 8 to 10 11 to 12	16 mcg 32 mcg 48 mcg 64 mcg
	Specialty Pharmacy to contact prescribing practitioner for adjustment	ents to the written orders specifi	ijed above.			
	ORDERS eck this box if you would like your patient to relations who are learning to administer their		rted* patient education for Tyvaso and/o	or Tyvaso DPI admini	stration. Nurse	e support* is
Note: Order for provider shou	or this drug is not inclusive of skilled nursing h uld enter a COMMUNITY CARE-GEC SKILLED Care Network) or VCA (Veteran Care Agreem	ome health services HOME CARE consul	t. The VA facility community care office v			-
patient's unde	ort is limited to education for patients and the erstanding of their therapy, and is not intended services, or serve as a reason to prescribe. If	ed to provide medic	al advice, replace a treatment plan from			
STEP 4	PRESCRIBER SIGNATURE: PRES	SCRIPTION AN	ID STATEMENT OF MEDICAL N	IECESSITY		
I certi	fy that the pulmonary hypertension associated with SICIAN'S SIGNATURE REQUIRED TO VA			and that I am personall	ly supervising th	e care of this patie
	cian's Signature: Dispense as W	/ritten	Substitution Allowed	<u> </u>	Date:	
AW State-	-Specific Dispense as Written (DAW) Selection Ve	rbiage:				

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(Physician attests this is his/her legal signature. NO STAMPS.) PRESCRIPTIONS MUST BE FAXED.

Patient Na	ame:			Date	of Birth:			
STEP 5	PAH - USE THIS SEC	CTION FOR PAH						
	duct Therapy Status for t laïve/New Restart	he Requested Drug: Transition	-	ecialty Pharmacy: ealth Group, Inc.	CVS Specialty	Patient Status Outpatient	Inpatient	WHO Group:
NYHA Funct	tional Class: II III IV	Weight:ft		Diabetic: Yes No	Allergies: Drug Allergi	ies Non-Drug A	allergies No	Known Allergies
	Target dose: 9 breaths (if 3 breaths are not tolera dose of 9 breaths (54 mcg TYVASO Inhalation Sy TYVASO Inhalation Sy The medication cost doe Prescriber may specif OR TYVASO DPI (trepros Target dose: 48 mcg Start with one 16-mcg carl session every week to sele than 64 mcg per treatmen TYVASO DPI Titration Ki 16 mcg (112 ct), 32 mcg TYVASO DPI Maintenan Inhale one breath per ca 16 mcg (112 ct) 32 Prescriber may specify treatment session, mor	1.74mg/2.9ml ampul (54 mcg) to 12 breaths (ted, use 1 to 2 breaths). Inc) to 12 breaths (72 mcg), 4 //stem Starter Kit (28-day so so not include the nebulized y any alternative or ad tinil) Inhalation Powd or 64 mcg or Othe stridge per treatment session cted target dose. Titration of the tession, more than 1 cartrit (28-day supply) Choose (112 ct), and 48 mcg (28 ct) the Kit (28-day supply) X /ortridge, 4 times daily. Ple mcg (112 ct) 48 mcg (1 any alternative or additi than 1 cartridge will be ing practitioner for adjustments to the wing practitioner for adjustment adjustm	(72 mcg), 4 time crease by an additimes daily. supply) 0 refills upply) X	es daily - Start with 3 tional 3 breaths per we refills refills plies. Those are prover and titration instruction instructio	breaths (18 mcg) eek, if tolerated, un ided at an addition ructions here: n, 4 times daily gth by 16 mcg per If the prescribed of	onal charge. (Check One) treatment dose is higher irred target dose.	TYVASO Nebulizer # of Breaths ≤5 6 to 7 8 to 10 11 to 12	16 mcg - 32 mcg - 48 mcg - 64 mcg -
NURSING	ORDERS							
available to p Note: Order for provider show (Community *Nurse support patient's und	eck this box if you would like patients who are learning to or this drug is not inclusive of uld enter a COMMUNITY CA Care Network) or VCA (Veteort is limited to education for erstanding of their therapy, a services, or serve as a reasonal care.	administer their Tyvaso to skilled nursing home he RE-GEC SKILLED HOME Coran Care Agreement) as r patients and their Unite and is not intended to pr	herapy. alth services. To CARE consult. The appropriate. Ind Therapeutics ovide medical a	request skilled nurs ne VA facility commu therapy, its administ dvice, replace a treat	ing services for h nity care office w ration, and/or the	nome inhalation the vill coordinate the n	erapy, the referr equested servic ended to supple	ing VA te through CCN ement a
STEP 5	PRESCRIBER SIGN	ATURE: PRESCRIP	TION AND	STATEMENT OF	MEDICAL N	ECESSITY		
CLCN	ify that the pulmonary arteri				d that I am persor	nally supervising the	e care of this pat	cient.
	cian's Signature:						Date:	
		Dispense as Written		Sul	stitution Allowed			
JAW	-Specific Dispense as Written (sician attests this is his/her led		PRESCRIPTIONS	MUST BE FAXED.				

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Referral Fax Cover Sheet

For VA Pharmacy:

Please fill out the information below and fax all pages of the referral form to the Specialty Pharmacy of your choice below.

Date:		No of Pages:
то	Accredo Health Group, Inc. FAX: 1.800.711.3526 Phone: 1.866.344.4874	CVS Specialty FAX: 1.877.943.1000 Phone: 1-877-242-2738
FROM	Name of VA Pharmacy Contact:	Facility Name:
	Fax:	Phone:
RE	Patient Name:	Patient Date of Birth:
	Comments:	

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