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

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

PRESCRIBER:

- **Send the VA Pharmacy** the completed enrollment form and the fax cover sheet. The VA Pharmacy will forward these on to the SP.
- **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.
- **Sign at the bottom** of page 2 or 3.

VA PHARMACY:

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

STEP 1 PATIENT INFORMATION

Name: First | Middle | Last

Date of Birth | Sex | Preferred Language

Address | Suite | City | State | Zip

Shipping Address (if different from home address) | Suite | City | State | Zip

Telephone ☐ Home ☐ Cell ☐ Work | Alternate Telephone ☐ Home ☐ Cell ☐ Work | Best Time to Call ☐ Morning ☐ Afternoon ☐ Evening ☐ Anytime

E-mail Address | Caregiver/Family Member

Caregiver Telephone ☐ Home ☐ Cell ☐ Work | Caregiver Alternate Telephone ☐ Home ☐ Cell ☐ Work | Caregiver E-mail Address

STEP 2 VA PHARMACY INFORMATION

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 ☐ Credit Card (call pharmacy contact) ☐ E-invoice Tungsten Network | Purchase Order # | Ship to ☐ Patient ☐ VA Location

STEP 3 PRESCRIBER INFORMATION

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 ☐ Phone ☐ E-mail ☐ Mail ☐ Fax

PCP (if different from prescribing MD) | PCP Phone

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Patient Name: _____ **Date of Birth:** _____

STEP 4 PH-ILD - USE THIS SECTION FOR PH-ILD

Patient Product Therapy Status for the Requested Drug: ☐ Naïve/New ☐ Restart ☐ Transition

Current Specialty Pharmacy: ☐ Accredo Health Group, Inc. ☐ CVS Specialty

Patient Status: ☐ Outpatient ☐ Inpatient

WHO Group: _____

Weight:_____☐ kg ☐ lb **Height:** ___ft___in

Diabetic: ☐ Yes ☐ No

Allergies: ☐ Drug Allergies ☐ Non-Drug Allergies ☐ No Known Allergies

TYVASO (treprostinil) 1.74mg/2.9ml ampule (0.6mg/ml) Inhalation Solution

Target dose: 9 breaths (54 mcg) to 12 breaths (72 mcg), 4 times daily - Start with 3 breaths (18 mcg) 4 times daily (if 3 breaths are not tolerated, use 1 to 2 breaths). Increase by an additional 1 breath per week, if tolerated, until the target dose of 9 breaths (54 mcg) to 12 breaths (72 mcg), 4 times daily.

☐ TYVASO Inhalation System Starter Kit (28-day supply) 0 refills

☐ TYVASO Inhalation System Refill Kit (28-day supply) X _____ refills

The medication cost does not include the nebulizer device and supplies. Those are provided at an additional charge.

Prescriber may specify any alternative or additional dosing and titration instructions here:

_____

OR

TYVASO DPI (treprostinil) Inhalation Powder

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 session every week to selected target dose. Titration schedule may vary based on tolerability. If the prescribed dose is higher than 64 mcg per treatment session, more than 1 cartridge will be needed per session.

TYVASO DPI Titration Kit (28-day supply) Choose one for titration phase.

☐ 16 mcg (112 ct), 32 mcg (112 ct), and 48 mcg (28 ct) 1 refill

TYVASO DPI Maintenance Kit (28-day supply) X _____ refills

Inhale one breath per cartridge, 4 times daily. Please check the box of the maintenance kit for the desired target dose.

☐ 16 mcg (112 ct) ☐ 32 mcg (112 ct) ☐ 48 mcg (112 ct) ☐ 64 mcg (112 ct)

Prescriber may specify any alternative or additional dosing and titration instructions here. If the prescribed dose is higher than 64 mcg per treatment session, more than 1 cartridge will be needed per session:

_____

Specialty Pharmacy to contact prescribing practitioner for adjustments to the written orders specified above.

Dose Comparison

 TYVASO Nebulizer # of Breaths	 TYVASO DPI Cartridge Strength
≤5	16 mcg
6 to 7	32 mcg
8 to 10	48 mcg
11 to 12	64 mcg

NURSING ORDERS

☐ Please check this box if you would like your patient to receive nurse-supported* patient education for Tyvaso and/or Tyvaso DPI administration. Nurse support* is available to patients who are learning to administer their Tyvaso therapy.

Note: Order for this drug is not inclusive of skilled nursing home health services. To request skilled nursing services for home inhalation therapy, the referring VA provider should enter a COMMUNITY CARE-GEC SKILLED HOME CARE consult. The VA facility community care office will coordinate the requested service through CCN (Community Care Network) or VCA (Veteran Care Agreement) as appropriate.

*Nurse support is limited to education for patients and their United Therapeutics therapy, its administration, and/or their disease. It is intended to supplement a patient's understanding of their therapy, and is not intended to provide medical advice, replace a treatment plan from the patient's doctor or nurse, directly provide case management services, or serve as a reason to prescribe. Program rules and limitations will apply.

STEP 4 PRESCRIBER SIGNATURE: PRESCRIPTION AND STATEMENT OF MEDICAL NECESSITY

SIGN HERE

I certify that the pulmonary hypertension associated with interstitial lung disease therapy ordered above is medically necessary and that I am personally supervising the care of this patient.

PHYSICIAN'S SIGNATURE REQUIRED TO VALIDATE PRESCRIPTIONS.

Physician's Signature: _____ **Date:** _____

DAW

Dispense as Written _____ **Substitution Allowed**

State-Specific Dispense as Written (DAW) Selection Verbiage: _____

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

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Patient Name: _____ **Date of Birth:** _____

STEP 5 PAH - USE THIS SECTION FOR PAH

Patient Product Therapy Status for the Requested Drug:
☐ Naïve/New ☐ Restart ☐ Transition

Current Specialty Pharmacy:
☐ Accredo Health Group, Inc. ☐ CVS Specialty

Patient Status:
☐ Outpatient ☐ Inpatient

WHO Group: _____

NYHA Functional Class:
☐ I ☐ II ☐ III ☐ IV

Weight:_____☐ kg ☐ lb
Height: ___ft___in

Diabetic:
☐ Yes ☐ No

Allergies:
☐ Drug Allergies ☐ Non-Drug Allergies ☐ No Known Allergies

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☐ TYVASO Inhalation System Starter Kit (28-day supply) 0 refills
☐ TYVASO Inhalation System Refill Kit (28-day supply) X _____ refills

The medication cost does not include the nebulizer device and supplies. Those are provided at an additional charge.

Prescriber may specify any alternative or additional dosing and titration instructions here:

_____

OR

TYVASO DPI (treprostinil) Inhalation Powder

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 session every week to selected target dose. Titration schedule may vary based on tolerability. If the prescribed dose is higher than 64 mcg per treatment session, more than 1 cartridge will be needed per session.

TYVASO DPI Titration Kit (28-day supply) Choose one for titration phase.
☐ 16 mcg (112 ct), 32 mcg (112 ct), and 48 mcg (28 ct) 1 refill

TYVASO DPI Maintenance Kit (28-day supply) X _____ refills

Inhale one breath per cartridge, 4 times daily. Please check the box of the maintenance kit for the desired target dose.
☐ 16 mcg (112 ct) ☐ 32 mcg (112 ct) ☐ 48 mcg (112 ct) ☐ 64 mcg (112 ct)

Prescriber may specify any alternative or additional dosing and titration instructions here. If the prescribed dose is higher than 64 mcg per treatment session, more than 1 cartridge will be needed per session:

_____

Specialty Pharmacy to contact prescribing practitioner for adjustments to the written orders specified above.

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STEP 5 PRESCRIBER SIGNATURE: PRESCRIPTION AND STATEMENT OF MEDICAL NECESSITY

SIGN HERE

I certify that the pulmonary arterial hypertension therapy ordered above is medically necessary and that I am personally supervising the care of this patient.
PHYSICIAN'S SIGNATURE REQUIRED TO VALIDATE PRESCRIPTIONS.

Physician's Signature: _____ _____ **Date:** _____
Dispense as Written **Substitution Allowed**

DAW

State-Specific Dispense as Written (DAW) Selection Verbiage: _____

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

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TYVASO DPI (treprostinil) INHALATION POWDER

TYVASO (treprostinil) INHALATION SOLUTION

FAX

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:

TO	☐ **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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