Orenitram® (treprostinil) Extended-Release Tablets VA Medical Facilities Referral Form

Orenitram is available through select specialty pharmacy (SP) providers. * REQUIRED FIELD.

orenitram® treprostinil EXTENDED-RELEASE TABLETS

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.

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.

Patient Name: _____ Date of Birth: _____

1 PATIENT INFORMATION

* Name: First * Middle * Last

* Date of Birth Sex * E-mail Address

* Home Address * City * State * Zip

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

Caregiver/Family Member Caregiver E-mail Address

* Caregiver Telephone: ☐ Home ☐ Cell ☐ Work Alternate Telephone: ☐ Home ☐ Cell ☐ Work OK to leave a message? ☐ Yes ☐ No

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 primary contact) ☐ E-invoice Tungsten Network

Purchase Order # _____

Ship to: ☐ Patient ☐ VA Location

3 PRESCRIBER INFORMATION

* Prescriber: First * Last

Facility Name * NPI # State License #

Address Suite City State Zip

Office Contact Name Telephone Fax

E-mail Preferred Method of Communication ☐ E-mail ☐ Phone ☐ Fax

United Therapeutics CORPORATION

Orenitram® (treprostinil) Extended-Release Tablets VA Medical Facilities 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. * REQUIRED FIELD.

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Patient Name: _____ Date of Birth: _____

4 MEDICAL INFORMATION / PATIENT EVALUATION

* **Patient UT PAH Product Therapy Status for the Requested Drug:** ☐ Naive/New ☐ Restart ☐ Transition

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

* **Patient Status:** ☐ Outpatient ☐ Inpatient

* **Diabetic:** ☐ Yes ☐ No * **WHO Group:** _____

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

* **Weight:** _____ ☐ kg ☐ lb * **Height:** _____ ft _____ in

* **Allergies:** ☐ Yes ☐ No ☐ No Known Drug Allergies

If yes _____

5 PRESCRIPTION INFORMATION (the prescription is only valid if received by fax)

Initial and Continued Titration

☐ **Titration Kit (3-month supply); 0 Refills**

Month 1 (NDC 66302-361-28), 126 tablets of 0.125 mg and 42 tablets of 0.25 mg
Month 2 (NDC 66302-362-56), 126 tablets of 0.125 mg and 210 tablets of 0.25 mg
Month 3 (NDC 66302-363-84), 126 tablets of 0.125 mg, 42 tablets of 0.25 mg and 84 tablets of 1 mg

Directions: Initiate at 0.125mg TID. Titrate by 0.125mg TID every 7 days until a dose of 1.5mg TID is achieved by end of titration pack month 3.

☐ **Prescription Beyond Month 3 (please select strengths to the right)**

Titrate by _____mg TID every _____ days until goal dose of _____mg TID is achieved

*** STRENGTHS - Select all appropriate strengths needed to reach target dose:**

☐ 0.125 mg (NDC 66302-300-01)
☐ 0.25 mg (NDC 66302-302-01)
☐ 1 mg (NDC 66302-310-01)
☐ 2.5 mg (NDC 66302-325-01)
☐ 5 mg (NDC 66302-350-01)

OR Alternate Dosing Instructions (please select strengths to the right)

☐ Initiate at _____ mg ☐ **TID OR** ☐ **BID (choose one)**. Titrate by _____ mg every ____ days until goal dose of _____ mg is achieved.

PRESCRIBER TO SPECIFY ANY ALTERNATIVE OR ADDITIONAL DOSING AND TITRATION INSTRUCTIONS HERE:

_____

_____

***DISPENSE:** Quantity sufficient for up to maximum allowable dose for one (1) month's supply. **Refills** ☐ 12 months **OR Refills** _____time(s)

DIRECTIONS: Take tablets by mouth with food

For Orenitram dosing and titration information, please see the Dosage and Administration section of the Prescribing Information.
Specialty Pharmacy to contact Prescriber for adjustments to written orders specified above.

NURSING ORDERS

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

Note: Order for this drug is not inclusive of skilled nursing home health services. To request skilled nursing services for home 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.

6 PRESCRIBER SIGNATURE: PRESCRIPTION AND STATEMENT OF MEDICAL NECESSITY

I certify that the medication ordered above is medically necessary and that I am personally supervising the care of this patient.
PHYSICIAN SIGNATURE REQUIRED TO VALIDATE PRESCRIPTIONS.

SIGN HERE

Physician's Signature (dispense as written): _____

Physician's Signature (substitution allowed): _____

Date: _____

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

United Therapeutics CORPORATION

FAX

orenitram®
treprostinil
EXTENDED-RELEASE TABLETS

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:	

United Therapeutics
A PUBLIC BENEFIT CORPORATION