# 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.**

orenitram® treprostinil EXTENDED-RELEASE TABLETS

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

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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. I authorize United Therapeutics ASSIST to act on my behalf for the limited purposes of transmitting this prescription to the appropriate pharmacy. 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.



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