

SPmix Enrollment Form for **REMODULIN® (treprostinil) Injection**

United Therapeutics Corporation Therapy Enrollment Form

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Please complete, sign, and fax Steps 1 and 2, along with requested clinical documentation, to your preferred Specialty Pharmacy using the included Fax Cover Sheet.

STEP 1 - PATIENT INFORMATION

A PATIENT INFORMATION

Name - First	Middle	Last
Date of Birth	Gender	Last 4 digits of SSN
Home Address		
City	State	Zip
Shipping Address (if different from home address)		
City	State	Zip
Telephone	Alternate Telephone	Cell Phone
E-mail Address	Best Time to Call ☐ Morning ☐ Afternoon ☐ Evening ☐ Anytime	
Caregiver/Family Member	Telephone	Alternate Telephone

☐ By checking this box I authorize SPS to leave a message with a caregiver/family member.

B INSURANCE INFORMATION

Pharmacy Benefits Manager		
Subscriber ID #	Group #	Telephone
Primary Medical Insurance:		Policy Holder/Relationship
Subscriber ID #	Group #	Telephone
Secondary Medical Insurance:		Policy Holder/Relationship
Subscriber ID #	Group #	Telephone

Please include copies of the front and back of the patient's medical and prescription insurance card(s).

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► Patient Name: _____ Date of Birth: _____

STEP 2 - PRESCRIBER INFORMATION AND PRESCRIPTION INFORMATION

C PRESCRIBER INFORMATION

Prescriber Name: First	Last	NPI #	State License #
Office/Clinic/Institution name		TIN #	
Address	City	State	Zip
Office Contact Name	Telephone	Fax	
E-mail Address	Preferred Method of Communication	☐ Phone ☐ Email ☐ Mail ☐ Fax	

D MEDICAL INFORMATION / PATIENT EVALUATION

Diagnosis - The following ICD-10 codes do not suggest approval, coverage or reimbursement for specific uses or indications

ICD-10 I27.0 Primary pulmonary hypertension ☐ Idiopathic PAH ☐ Heritable PAH	ICD-10 I27.21 Secondary pulmonary arterial hypertension: ☐ Connective tissue disease ☐ Congenital Heart Disease ☐ Portal Hypertension ☐ Drugs/Toxins induced ☐ HIV ☐ Other: _____	Other ICD-10: _____
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Allergies: ☐ Yes ☐ No ☐ No Known Drug Allergies
If yes _____

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

Diabetic: ☐ Yes ☐ No

E PRESCRIPTION INFORMATION

☐ **REMODULIN® (treprostinil) Injection**

Vial concentration: ☐ 0.4 mg/mL (20-mL vial) ☐ 1 mg/mL (20-mL vial) ☐ 2.5 mg/mL (20-mL vial) ☐ 5 mg/mL (20-mL vial) ☐ 10 mg/mL (20-mL vial)

Refills 1 year or _____ **Patient dosing weight:** _____ kg ☐ lb

Diluent: Remodulin® Sterile Diluent for Injection

Infusion Type: ☐ Intravenous continuous infusion

Dosing and Titration Instructions: For Remodulin dosing and titration information, please see the Dosage and Administration section of the Prescribing Information.

Specify Current Dose: _____ Concentration: _____ Pump rate: _____

- Dispense 1 week of Remodulin (treprostinil) premixed cassettes containing prescribed concentration (compounded by specialty pharmacy per USP 797 guidelines), ancillary supplies, and medical equipment necessary to administer medication. Cassette to be changed 48 hours after infusion start or as directed.
- Dispense 1 week of Remodulin (treprostinil) for emergency supply, and quantity sufficient of prescribed diluent, syringes, needles, and any other necessary supplies to mix and administer for emergency supply.
- Dispense teaching kits (diluent, syringes, needles, and any other necessary supplies to mix and assess patient's mixing skills). Quantity: up to 4 kits per quarter and refill x1 year.
- Dispense 1-month of needles, syringes, ancillary supplies, and medical equipment necessary to administer medication.

Central Venous Catheter Care: ☐ Dressing change every _____ days ☐ Per IV standard of care

Pumps: ☐ Ambulatory IV Infusion Pumps for Remodulin (2)

Nursing Orders - RN visits to provide assessment and education on administration, dosing, titration and transitioning to pre-mix cassettes with the use of teaching kits

☐ quarterly or ☐ every 6 months

The Prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the Prescriber.

F PRESCRIBER SIGNATURE: PRESCRIPTION AND STATEMENT OF MEDICAL NECESSITY

I certify that the pulmonary arterial hypertension therapy ordered above is medically necessary and that I am personally supervising the care of this patient who has been on Remodulin IV for the past 3 months and a steady dose for at least 1 month. I authorize United Therapeutics Corporation, its affiliates, agents, and contractors (collectively, United Therapeutics) to act on my behalf for the limited purposes of transmitting this prescription to the appropriate pharmacy designated by the patient utilizing their benefit plan. **PHYSICIAN SIGNATURE REQUIRED TO VALIDATE PRESCRIPTIONS.**

DISPENSE AS WRITTEN Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute

MAY SUBSTITUTE Product Selection Permitted / Substitution Permissible

SIGN
HERE

Prescriber's Signature: _____ Date: _____

OR

Prescriber's Signature: _____ Date: _____

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

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Please Note: Each practitioner is solely responsible for ensuring the accuracy of the information submitted. State- and Payer-specific requirements may vary.

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STEP 3 - FAX

FAX COVER SHEET

Date:

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:

Facility Name:

Fax:

Included in this fax:

☐ **Completed SPmix Enrollment Form including**

☐ Page 1 - Patient/Insurance Information

☐ Page 2 - Prescriber/Prescription Information

☐ **Medication History**

Number of Pages:

Comments:

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