United Therapeutics Cares®

orenitram® treprostinil EXTENDED-RELEASE TABLETS

ANNOTATED SAMPLE

Before submitting a referral

Work with your patient to complete all required sections of the referral form. Completed forms can be faxed to 1-800-380-5294 using the provided referral fax cover sheet. Visit unitedtherapeuticscares.com to learn more and download the digital referral form.

Use this checklist as a guide to complete the referral form.

Please provide complete patient information. It helps to list **caregiver or family member** information and indicate the **best time to call**.

Provide your **direct contact information** so the Specialty Pharmacy can reach you.

Provide all insurance cards **(front and back)** and pharmacy and medical benefits information to help the Specialty Pharmacy determine optimal coverage. **Incomplete information could cause delay.**

If known, select your patient's preferred Specialty Pharmacy. Note that payer requirements may limit which pharmacy the patient may receive medication from.

United Therapeutics Cares®

Questions about filling out this form? Reach out to the United Therapeutics Cares® Team.

Mon–Fri, 8:30 am–7 pm ET
P: 1-844-864-8437
F: 1-800-380-5294

orenitram® treprostinil EXTENDED-RELEASE TABLETS

Orenitram® (treprostinil) Enrollment and Referral Form

Follow the steps to prescribe Orenitram for your patient and get them started with support from United Therapeutics Cares.

- Complete all required sections
- Provide copies of insurance cards (front and back)
- Gather patient signatures
- Fax referral and documentation

*Required field

Who is the patient?

*First name, middle initial | *Last name
*Date of birth (MM/DD/YYYY) | *Gender: ◯ Male ◯ Female | *Email
*Home address | *City | *State | *ZIP
Shipping address (if different from home) | City | State | ZIP
*Phone | ◯ Personal ◯ Work | Best time to call: ◯ Morning ◯ Afternoon ◯ Evening
OK to leave a message? ◯ Yes ◯ No | Primary language
Caregiver/Family member name | Caregiver email
Caregiver phone | ◯ Personal ◯ Work | Best time to call: ◯ Morning ◯ Afternoon ◯ Evening
The patient authorizes the caregiver to receive information regarding the patient's treatment and care: ◯ Yes ◯ No
*Patient therapy status for Orenitram: ◯ New ◯ Restart ◯ Transition

Who is the prescriber?

*First name | *Last name
*Office/Clinic/Institution | *State license # | *NPI
*Office address | *City | *State | *ZIP
*Office contact | *Phone
Office contact email | *Fax

What is the patient's insurance?

Primary prescription insurance
Subscriber ID # | Group # | Phone
Primary medical insurance | Policy holder
Subscriber ID # | Group # | Phone

Who is the preferred Specialty Pharmacy?

◯ Accredo Health Group, Inc. ◯ CVS Specialty Pharmacy

Page 1 of 4

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Orenitram® (treprostinil) Enrollment and Referral Form

Indicate appropriate WHO group.

Include all patient disease information.

List patient's **current or previous PAH medications**, as it may be required by the insurance provider.

Determine how the patient will start Orenitram. Select one of the following two options:

① **Titration Kit (3-month supply) and prescription beyond month 3**

- Complete the prescription beyond month 3 to ensure the patient continues Orenitram after the Titration Kit.
- Patient will receive individual-strength bottles for their prescription after the first 3 months.

② **Alternate dosing**

- For patients who are not starting on the Titration Kit, including patients transitioning from another therapy, starting at a higher dose, or requiring faster titration.
- Patient will receive individual-strength bottles.

For either approach, select all strengths needed to reach target dose

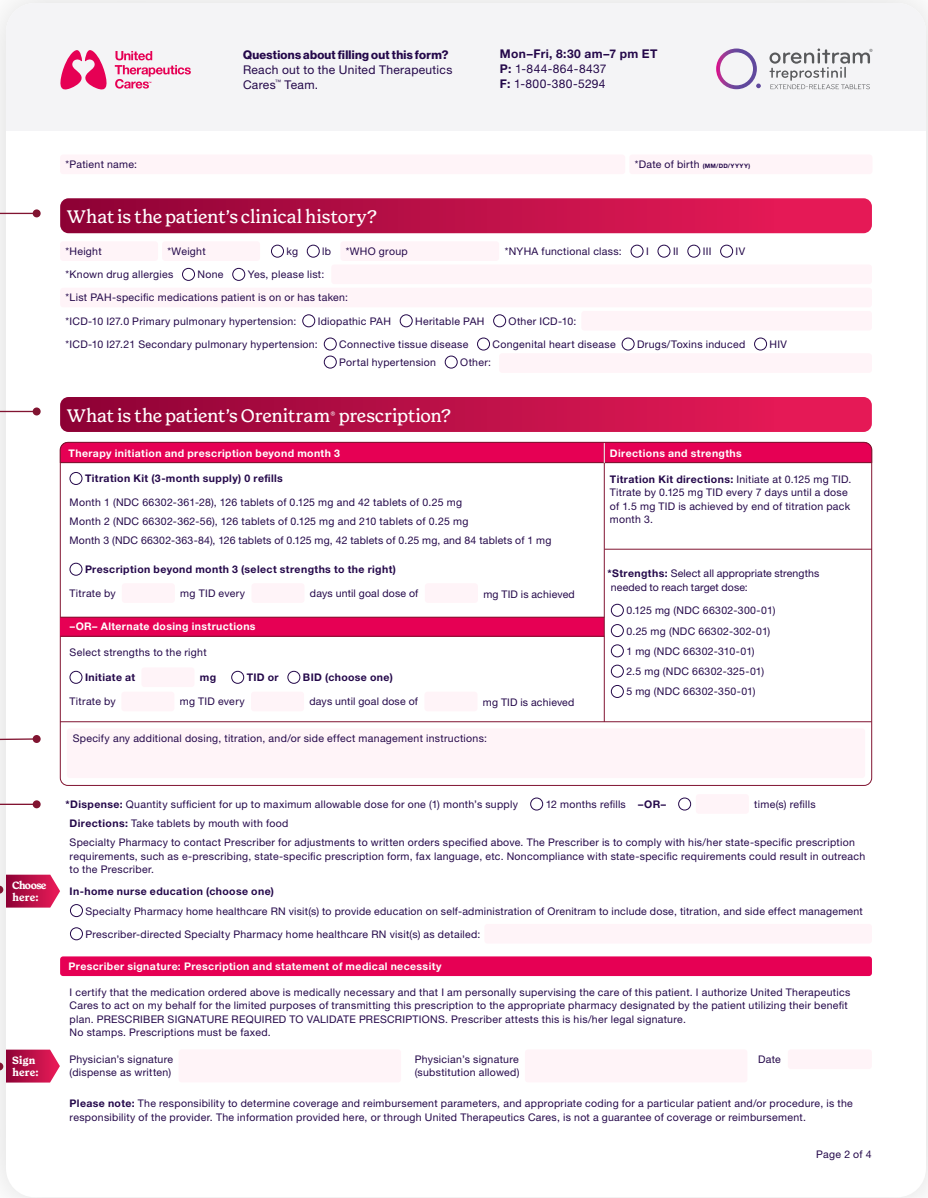
Checking all strengths helps minimize delays as the patient continues titrating and needs higher dosing strengths.

Provide any standing protocols or **preferred approaches to side effect management**. You can also include this type of information with the other clinical documents with a note here to "see attached."

Select **refill quantity**.

Select which **type of nurse visit** you would like your patient to receive. If necessary, provide additional details.

Your **signature is required** for either "dispense as written" or "substitution allowed" for submission.



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*Patient name: *Date of birth (MM/DD/YYYY)

What is the patient's clinical history?

*Height *Weight ◯ kg ◯ lb *WHO group *NYHA functional class: ◯ I ◯ II ◯ III ◯ IV

*Known drug allergies ◯ None ◯ Yes, please list:

*List PAH-specific medications patient is on or has taken:

*ICD-10 I27.0 Primary pulmonary hypertension: ◯ Idiopathic PAH ◯ Heritable PAH ◯ Other ICD-10:

*ICD-10 I27.21 Secondary pulmonary hypertension: ◯ Connective tissue disease ◯ Congenital heart disease ◯ Drugs/Toxins induced ◯ HIV ◯ Portal hypertension ◯ Other:

What is the patient's Orenitram® prescription?

Therapy initiation and prescription beyond month 3

◯ **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

◯ **Prescription beyond month 3 (select strengths to the right)**

Titrate by mg TID every days until goal dose of mg TID is achieved

–OR– Alternate dosing instructions

Select strengths to the right

◯ **Initiate at mg ◯ TID or ◯ BID (choose one)**

Titrate by mg TID every days until goal dose of mg TID is achieved

Directions and strengths

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

***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)

Specify any additional dosing, titration, and/or side effect management instructions:

***Dispense:** Quantity sufficient for up to maximum allowable dose for one (1) month's supply ◯ 12 months refills **–OR–** ◯ time(s) refills

Directions: Take tablets by mouth with food

Specialty Pharmacy to contact Prescriber for adjustments to written orders specified above. The Prescriber is to comply with his/her state-specific prescription requirements, such as e-prescribing, state-specific prescription form, fax language, etc. Noncompliance with state-specific requirements could result in outreach to the Prescriber.

Choose here:

In-home nurse education (choose one)

◯ Specialty Pharmacy home healthcare RN visit(s) to provide education on self-administration of Orenitram to include dose, titration, and side effect management

◯ Prescriber-directed Specialty Pharmacy home healthcare RN visit(s) as detailed:

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 Cares 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. PRESCRIBER SIGNATURE REQUIRED TO VALIDATE PRESCRIPTIONS. Prescriber attests this is his/her legal signature. No stamps. Prescriptions must be faxed.

Sign here:

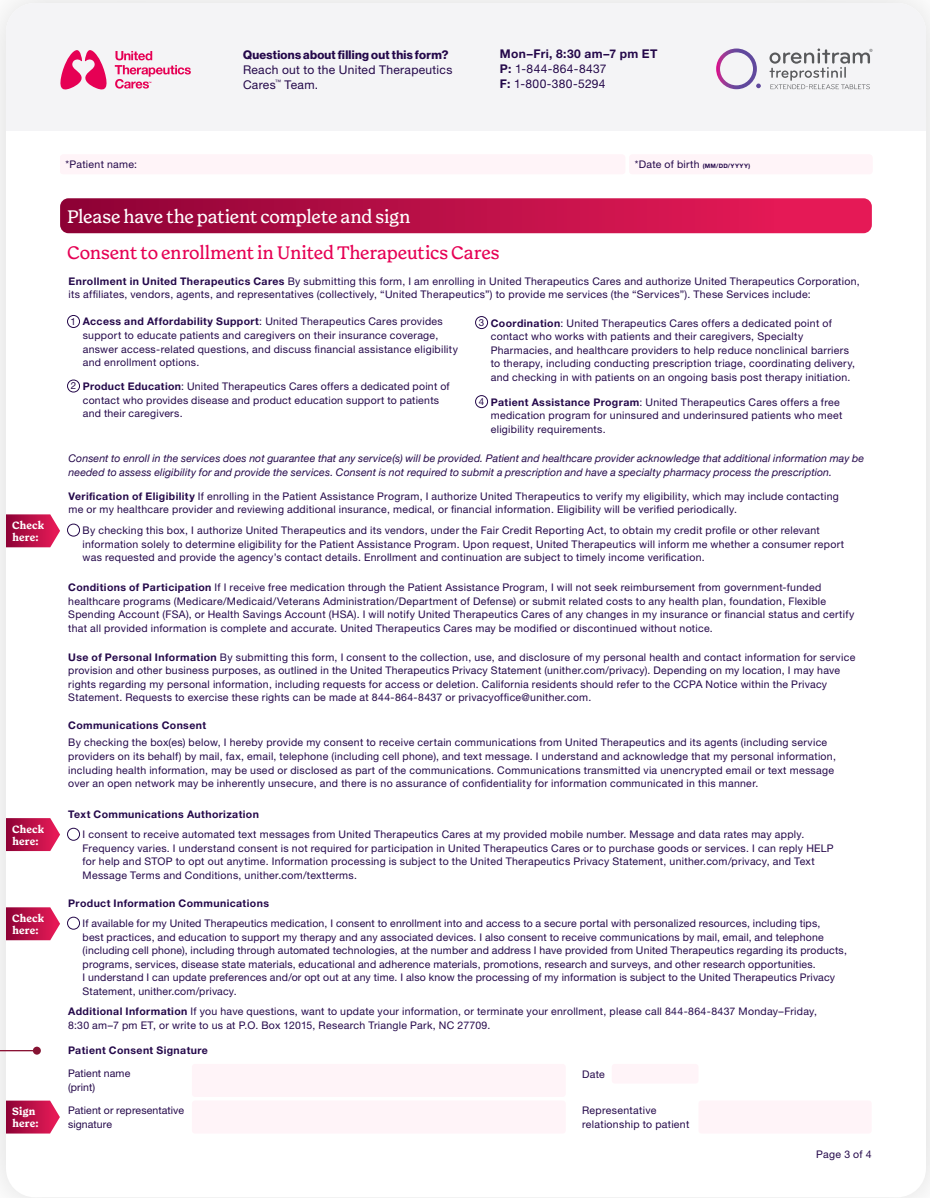
Physician's signature (dispense as written) Physician's signature (substitution allowed) Date

Please note: The responsibility to determine coverage and reimbursement parameters, and appropriate coding for a particular patient and/or procedure, is the responsibility of the provider. The information provided here, or through United Therapeutics Cares, is not a guarantee of coverage or reimbursement.

Page 2 of 4

ANNOTATED SAMPLE

Orenitram® (treprostinil) Enrollment and Referral Form



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orenitram® treprostinil EXTENDED-RELEASE TABLETS

*Patient name:

*Date of birth (MM/DD/YYYY)

Please have the patient complete and sign

Consent to enrollment in United Therapeutics Cares

Enrollment in United Therapeutics Cares By submitting this form, I am enrolling in United Therapeutics Cares and authorize United Therapeutics Corporation, its affiliates, vendors, agents, and representatives (collectively, "United Therapeutics") to provide me services (the "Services"). These Services include:

① **Access and Affordability Support**: United Therapeutics Cares provides support to educate patients and caregivers on their insurance coverage, answer access-related questions, and discuss financial assistance eligibility and enrollment options.

② **Product Education**: United Therapeutics Cares offers a dedicated point of contact who provides disease and product education support to patients and their caregivers.

③ **Coordination**: United Therapeutics Cares offers a dedicated point of contact who works with patients and their caregivers, Specialty Pharmacies, and healthcare providers to help reduce nonclinical barriers to therapy, including conducting prescription triage, coordinating delivery, and checking in with patients on an ongoing basis post therapy initiation.

④ **Patient Assistance Program**: United Therapeutics Cares offers a free medication program for uninsured and underinsured patients who meet eligibility requirements.

Consent to enroll in the services does not guarantee that any service(s) will be provided. Patient and healthcare provider acknowledge that additional information may be needed to assess eligibility for and provide the services. Consent is not required to submit a prescription and have a specialty pharmacy process the prescription.

Verification of Eligibility If enrolling in the Patient Assistance Program, I authorize United Therapeutics to verify my eligibility, which may include contacting me or my healthcare provider and reviewing additional insurance, medical, or financial information. Eligibility will be verified periodically.

Check here: ◯ By checking this box, I authorize United Therapeutics and its vendors, under the Fair Credit Reporting Act, to obtain my credit profile or other relevant information solely to determine eligibility for the Patient Assistance Program. Upon request, United Therapeutics will inform me whether a consumer report was requested and provide the agency's contact details. Enrollment and continuation are subject to timely income verification.

Conditions of Participation If I receive free medication through the Patient Assistance Program, I will not seek reimbursement from government-funded healthcare programs (Medicare/Medicaid/Veterans Administration/Department of Defense) or submit related costs to any health plan, foundation, Flexible Spending Account (FSA), or Health Savings Account (HSA). I will notify United Therapeutics Cares of any changes in my insurance or financial status and certify that all provided information is complete and accurate. United Therapeutics Cares may be modified or discontinued without notice.

Use of Personal Information By submitting this form, I consent to the collection, use, and disclosure of my personal health and contact information for service provision and other business purposes, as outlined in the United Therapeutics Privacy Statement (unither.com/privacy). Depending on my location, I may have rights regarding my personal information, including requests for access or deletion. California residents should refer to the CCPA Notice within the Privacy Statement. Requests to exercise these rights can be made at 844-864-8437 or privacyoffice@unither.com.

Communications Consent

By checking the box(es) below, I hereby provide my consent to receive certain communications from United Therapeutics and its agents (including service providers on its behalf) by mail, fax, email, telephone (including cell phone), and text message. I understand and acknowledge that my personal information, including health information, may be used or disclosed as part of the communications. Communications transmitted via unencrypted email or text message over an open network may be inherently unsecure, and there is no assurance of confidentiality for information communicated in this manner.

Text Communications Authorization

Check here: ◯ I consent to receive automated text messages from United Therapeutics Cares at my provided mobile number. Message and data rates may apply. Frequency varies. I understand consent is not required for participation in United Therapeutics Cares or to purchase goods or services. I can reply HELP for help and STOP to opt out anytime. Information processing is subject to the United Therapeutics Privacy Statement, unither.com/privacy, and Text Message Terms and Conditions, unither.com/textterms.

Product Information Communications

Check here: ◯ If available for my United Therapeutics medication, I consent to enrollment into and access to a secure portal with personalized resources, including tips, best practices, and education to support my therapy and any associated devices. I also consent to receive communications by mail, email, and telephone (including cell phone), including through automated technologies, at the number and address I have provided from United Therapeutics regarding its products, programs, services, disease state materials, educational and adherence materials, promotions, research and surveys, and other research opportunities. I understand I can update preferences and/or opt out at any time. I also know the processing of my information is subject to the United Therapeutics Privacy Statement, unither.com/privacy.

Additional Information If you have questions, want to update your information, or terminate your enrollment, please call 844-864-8437 Monday–Friday, 8:30 am–7 pm ET, or write to us at P.O. Box 12015, Research Triangle Park, NC 27709.

Patient Consent Signature

Patient name (print) | Date

Sign here: Patient or representative signature | Representative relationship to patient

Page 3 of 4

For patients who may need financial assistance, checking this box authorizes United Therapeutics to verify eligibility.

By checking this box, patients are opting into receiving program text messages.

By checking this box, patients gain access to a personalized portal and additional therapy support education and resources from United Therapeutics.

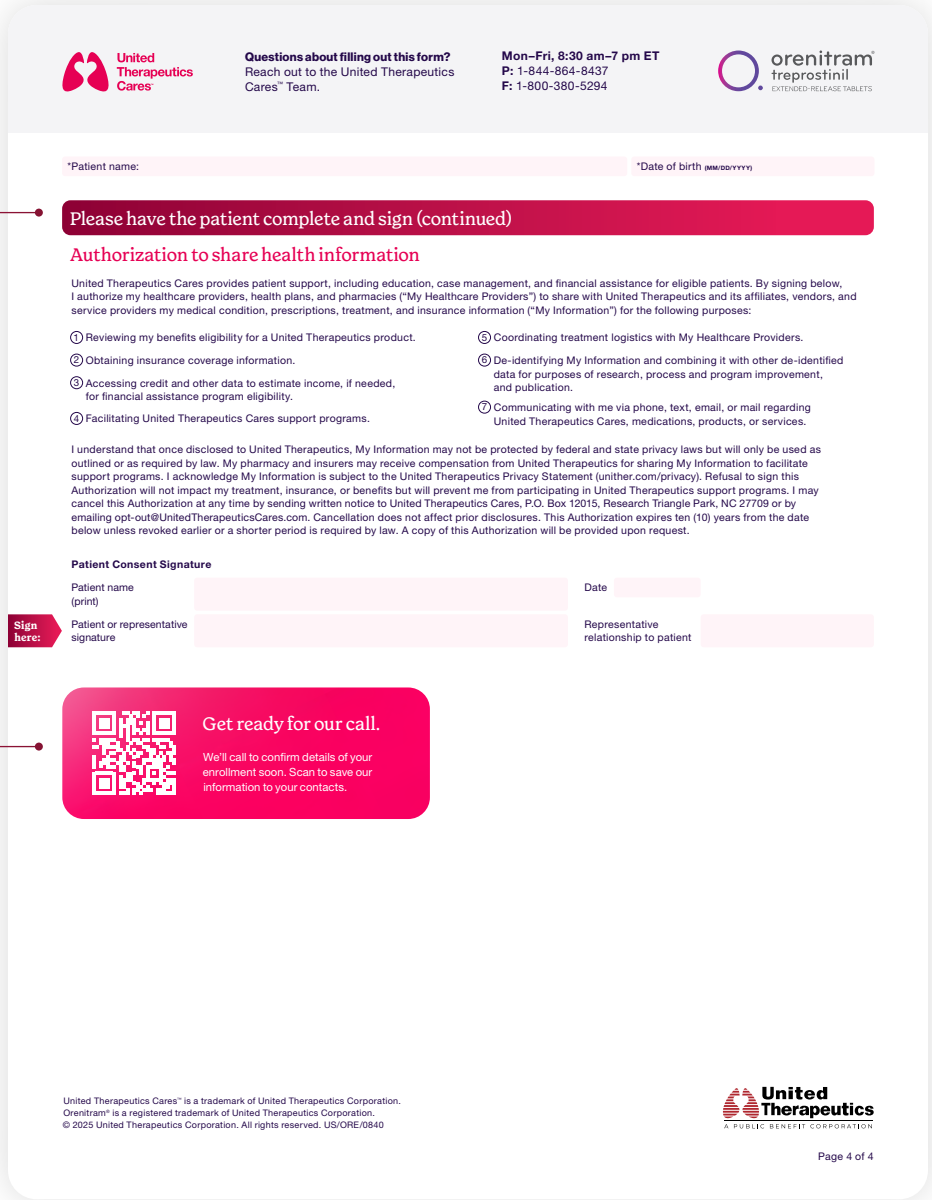
Your patient's printed name, signature, and the date are required to enroll in United Therapeutics Cares and receive Specialty Pharmacy services.

ANNOTATED SAMPLE

Orenitram® (treprostinil) Enrollment and Referral Form

A patient's printed name, signature, and the date are required to share health information with United Therapeutics Cares and receive Specialty Pharmacy services.

Encourage your patient to scan the QR code to save United Therapeutics Cares to their contacts.



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*Patient name:

*Date of birth (MM/DD/YYYY)

Please have the patient complete and sign (continued)

Authorization to share health information

United Therapeutics Cares provides patient support, including education, case management, and financial assistance for eligible patients. By signing below, I authorize my healthcare providers, health plans, and pharmacies ("My Healthcare Providers") to share with United Therapeutics and its affiliates, vendors, and service providers my medical condition, prescriptions, treatment, and insurance information ("My Information") for the following purposes:

1. Reviewing my benefits eligibility for a United Therapeutics product.
2. Obtaining insurance coverage information.
3. Accessing credit and other data to estimate income, if needed, for financial assistance program eligibility.
4. Facilitating United Therapeutics Cares support programs.
5. Coordinating treatment logistics with My Healthcare Providers.
6. De-identifying My Information and combining it with other de-identified data for purposes of research, process and program improvement, and publication.
7. Communicating with me via phone, text, email, or mail regarding United Therapeutics Cares, medications, products, or services.

I understand that once disclosed to United Therapeutics, My Information may not be protected by federal and state privacy laws but will only be used as outlined or as required by law. My pharmacy and insurers may receive compensation from United Therapeutics for sharing My Information to facilitate support programs. I acknowledge My Information is subject to the United Therapeutics Privacy Statement (unither.com/privacy). Refusal to sign this Authorization will not impact my treatment, insurance, or benefits but will prevent me from participating in United Therapeutics support programs. I may cancel this Authorization at any time by sending written notice to United Therapeutics Cares, P.O. Box 12015, Research Triangle Park, NC 27709 or by emailing opt-out@UnitedTherapeuticsCares.com. Cancellation does not affect prior disclosures. This Authorization expires ten (10) years from the date below unless revoked earlier or a shorter period is required by law. A copy of this Authorization will be provided upon request.

Patient Consent Signature

Patient name (print)

Date

Sign here: Patient or representative signature

Representative relationship to patient

Get ready for our call.

We'll call to confirm details of your enrollment soon. Scan to save our information to your contacts.

United Therapeutics A PUBLIC BENEFIT CORPORATION

Page 4 of 4

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