United Therapeutics Cares™

# Referral Fax Cover Sheet

**P:** +1-844-864-8437
**F:** +1-800-380-5294
unitedtherapeuticscares.com

**Please complete the following and fax to United Therapeutics Cares**

- Fill in all sections of the referral form for the United Therapeutics product being prescribed
- Include copies of insurance card(s), front and back
- Attach necessary clinical documents, including test results for right heart catheterization, high-resolution CT scan (PH-ILD only), echocardiogram, and history and physical
- Share the United Therapeutics Cares brochure with your patient, review services, and let them know a Patient Navigator will be calling. Enrollment in United Therapeutics Cares is optional
- Fax this cover sheet with the referral form and necessary clinical documentation to 1-800-380-5294

| | | |
|---|---|---|
| **To:** | **From:** | **Date:** |
| **Facility name:** | **Fax:** | **Phone:** |
| **Product prescribed:** ◯ Orenitram® (treprostinil) ◯ Remodulin® (treprostinil) ◯ TYVASO® (treprostinil) ◯ TYVASO DPI® (treprostinil) | | **Pages:** |
| Preferred Specialty Pharmacy: ◯ Accredo Health Group, Inc ◯ CVS Specialty Pharmacy<br>*To be used if patient's payer does not mandate a particular Specialty Pharmacy be used* | | |
| **Subject:** | | |

**Comments:**

United Therapeutics
A PUBLIC BENEFIT CORPORATION

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.

*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

*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 | Directions and strengths |
|---|---|
| ◯ **Titration Kit (3-month supply) 0 refills**<br>Month 1 (NDC 66302-361-28), 126 tablets of 0.125 mg and 42 tablets of 0.25 mg<br>Month 2 (NDC 66302-362-56), 126 tablets of 0.125 mg and 210 tablets of 0.25 mg<br>Month 3 (NDC 66302-363-84), 126 tablets of 0.125 mg, 42 tablets of 0.25 mg, and 84 tablets of 1 mg | **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. |
| ◯ **Prescription beyond month 3 (select strengths to the right)**<br>Titrate by ____ mg TID every ____ days until goal dose of ____ mg TID is achieved | ***Strengths:** Select all appropriate strengths needed to reach target dose:<br>◯ 0.125 mg (NDC 66302-300-01)<br>◯ 0.25 mg (NDC 66302-302-01)<br>◯ 1 mg (NDC 66302-310-01)<br>◯ 2.5 mg (NDC 66302-325-01)<br>◯ 5 mg (NDC 66302-350-01) |
| **–OR– Alternate dosing instructions**<br>Select strengths to the right<br>◯ **Initiate at** ____ **mg** ◯ **TID or** ◯ **BID (choose one)**<br>Titrate by ____ mg TID every ____ days until goal dose of ____ mg TID is achieved | |

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.

*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 authorized representative signature

Relationship to patient

*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 authorized representative signature

Relationship to patient

*Patient name:

*Date of birth (MM/DD/YYYY)

## Please have the patient complete and sign (continued)

# United Therapeutics Cares Hospital to Home Program

The United Therapeutics Cares Hospital to Home Program is a program offered by United Therapeutics Corporation ("United Therapeutics") that provides a limited supply of Orenitram® (treprostinil) to certain patients who are currently hospitalized, have been prescribed Orenitram® (treprostinil) consistent with the approved labeling, and are experiencing a delay in coverage determination.

You may be eligible to participate in the United Therapeutics Cares Hospital to Home Program if you meet certain eligibility requirements. This consent applies if you are determined to be eligible for participation in the Hospital to Home Program.

A request to participate in the Hospital to Home Program does not guarantee that you will be approved for participation.

**Terms and Conditions for Hospital to Home**

- You may be eligible to participate in the United Therapeutics Cares Hospital to Home Program (the "Program"), which is a limited and temporary patient support program, if you meet certain eligibility requirements.
- You may be eligible to participate in the Program if you have completed enrollment in United Therapeutics Cares, which includes providing consent to enroll and authorization to share your data.
- You may be eligible to participate in the Program if you are currently hospitalized and have been prescribed Orenitram® consistent with the approved labeling–including transitioning from parenteral therapy as applicable.
- Participation in the Program is not conditioned on any past, present, or future purchase requirement.
- You may be eligible to participate in the Program if you are experiencing a delay related to coverage determination that is at least 3 days from the date of the Prior Authorization submission.
- If eligible for participation in the Program, patients are free to discontinue the Program at any time.
- A request to participate in the Program does not guarantee that you will be approved for participation.
- If eligible for participation in the Program, you should not seek reimbursement from your insurance for the medication that you receive at no cost. Medicare patients specifically should not seek reimbursement from Medicare Part D Plan and should not seek to apply any costs of the medication to their true-out-of-pocket (TrOOP) costs. Medicare Part D plans will be informed about a patient's participation in the Program.
- Please contact us immediately if anything changes with your insurance coverage or prescription.
- The Program is not available to patients who are uninsured. The Program does not provide health insurance, and participation in the Program does not guarantee any insurance coverage.
- United Therapeutics Corporation reserves the right to modify or terminate this Program at any time without notice.
- Patient must reside in the U.S. or U.S. territories and be under the direct care of a physician who is practicing medicine and licensed in such jurisdiction.
- Patient must receive health care services within the U.S. or U.S. territories.

**Please acknowledge and confirm the following:**

I confirm that all information provided to United Therapeutics Cares is complete and accurate to the best of my knowledge. This consent applies if you are determined to be eligible for participation in the Hospital to Home Program and comply with the terms of the Hospital to Home Program.

**Patient Consent Signature**

Patient name (print)

Date

**Sign here:** Patient or authorized representative signature

Relationship to patient

**Prescriber Signature**

**Sign here:** Physician's signature (dispense as written)

Physician's signature (substitution allowed)

Date

Prior authorization submitted on (optional):

**To be eligible for the Hospital to Home program, your patient must provide consent and authorization to enroll into United Therapeutics Cares. Please fax this referral form to United Therapeutics Cares if your patient is seeking to enroll in the Hospital to Home program.**

## Get ready for our call.

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



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