United Therapeutics Cares

TYVASO (treprostinil) INHALATION SOLUTION

TYVASO DPI (treprostinil) INHALATION POWDER

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

TYVASO (treprostinil) INHALATION SOLUTION

TYVASO DPI (treprostinil) INHALATION POWDER

TYVASO® (treprostinil) & TYVASO DPI® (treprostinil) Enrollment and Referral Form

Follow the steps to prescribe TYVASO or TYVASO DPI 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

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 **TYVASO**: ◯ New ◯ Restart ◯ Transition | *Patient therapy status for **TYVASO DPI**: ◯ 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 6

ANNOTATED SAMPLE

TYVASO® (treprostinil) & TYVASO DPI® (treprostinil) Enrollment and Referral Form

Use this page for PH-ILD patients

Indicate appropriate WHO group.

Select **one PH** diagnosis code and **one ILD** specific diagnosis code.

For TYVASO Inhalation Solution

Select target dose and **note refills** for your patient to initiate and continue therapy.

For TYVASO DPI Inhalation Powder

1. Select **target dose**.
2. Select **Titration Kit** (if applicable).
3. Select all **Maintenance Kits** with refills noted if your patient will continue therapy.

For either prescription

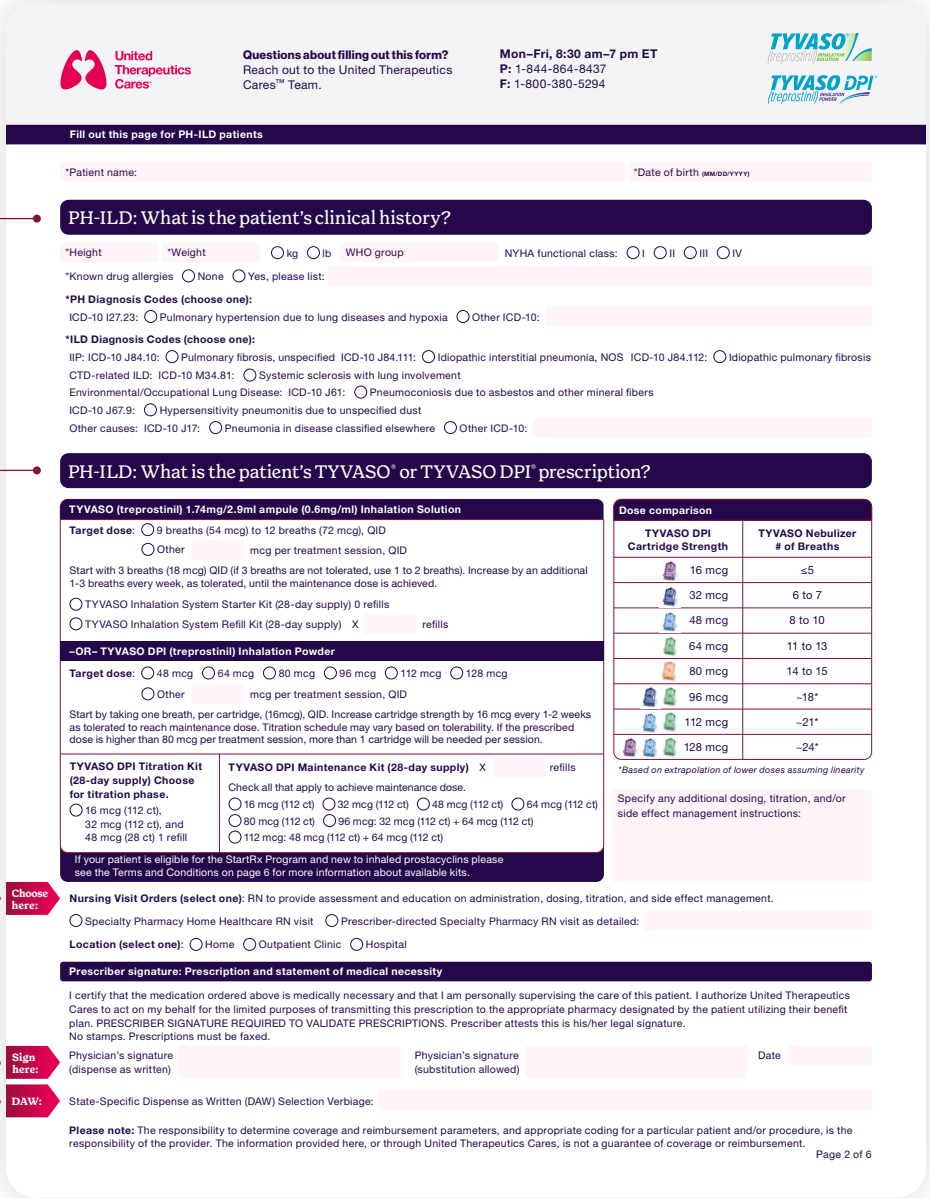
Refer to the **comparison chart** of doses between TYVASO DPI and TYVASO Nebulizer.

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 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.

DAW **selection verbiage is required** for submission.



United Therapeutics Cares®

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P: 1-844-864-8437
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TYVASO® (treprostinil) inhalation solution
TYVASO DPI® (treprostinil) inhalation powder

Fill out this page for PH-ILD patients

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

PH-ILD: 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:

***PH Diagnosis Codes (choose one):**
ICD-10 I27.23: ◯ Pulmonary hypertension due to lung diseases and hypoxia ◯ Other ICD-10:

***ILD Diagnosis Codes (choose one):**
IIP: ICD-10 J84.10: ◯ Pulmonary fibrosis, unspecified ICD-10 J84.111: ◯ Idiopathic interstitial pneumonia, NOS ICD-10 J84.112: ◯ Idiopathic pulmonary fibrosis
CTD-related ILD: ICD-10 M34.81: ◯ Systemic sclerosis with lung involvement
Environmental/Occupational Lung Disease: ICD-10 J61: ◯ Pneumoconiosis due to asbestos and other mineral fibers
ICD-10 J67.9: ◯ Hypersensitivity pneumonitis due to unspecified dust
Other causes: ICD-10 J17: ◯ Pneumonia in disease classified elsewhere ◯ Other ICD-10:

PH-ILD: What is the patient's TYVASO® or TYVASO DPI® prescription?

TYVASO (treprostinil) 1.74mg/2.9ml ampule (0.6mg/ml) Inhalation Solution

Target dose: ◯ 9 breaths (54 mcg) to 12 breaths (72 mcg), QID
◯ Other mcg per treatment session, QID

Start with 3 breaths (18 mcg) QID (if 3 breaths are not tolerated, use 1 to 2 breaths). Increase by an additional 1-3 breaths every week, as tolerated, until the maintenance dose is achieved.

◯ TYVASO Inhalation System Starter Kit (28-day supply) 0 refills
◯ TYVASO Inhalation System Refill Kit (28-day supply) X refills

–OR– TYVASO DPI (treprostinil) Inhalation Powder

Target dose: ◯ 48 mcg ◯ 64 mcg ◯ 80 mcg ◯ 96 mcg ◯ 112 mcg ◯ 128 mcg
◯ Other mcg per treatment session, QID

Start by taking one breath, per cartridge, (16mcg), QID. Increase cartridge strength by 16 mcg every 1-2 weeks as tolerated to reach maintenance dose. Titration schedule may vary based on tolerability. If the prescribed dose is higher than 80 mcg per treatment session, more than 1 cartridge will be needed per session.

TYVASO DPI Titration Kit (28-day supply) Choose for titration phase.
◯ 16 mcg (112 ct), 32 mcg (112 ct), and 48 mcg (28 ct) 1 refill

TYVASO DPI Maintenance Kit (28-day supply) X refills
Check all that apply to achieve maintenance dose.
◯ 16 mcg (112 ct) ◯ 32 mcg (112 ct) ◯ 48 mcg (112 ct) ◯ 64 mcg (112 ct)
◯ 80 mcg (112 ct) ◯ 96 mcg: 32 mcg (112 ct) + 64 mcg (112 ct)
◯ 112 mcg: 48 mcg (112 ct) + 64 mcg (112 ct)

If your patient is eligible for the StartRx Program and new to inhaled prostacyclins please see the Terms and Conditions on page 6 for more information about available kits.

Dose comparison

TYVASO DPI Cartridge Strength	TYVASO Nebulizer # of Breaths
16 mcg	≤5
32 mcg	6 to 7
48 mcg	8 to 10
64 mcg	11 to 13
80 mcg	14 to 15
96 mcg	~18*
112 mcg	~21*
128 mcg	~24*

*Based on extrapolation of lower doses assuming linearity

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

Choose here:

Nursing Visit Orders (select one): RN to provide assessment and education on administration, dosing, titration, and side effect management.
◯ Specialty Pharmacy Home Healthcare RN visit ◯ Prescriber-directed Specialty Pharmacy RN visit as detailed:
Location (select one): ◯ Home ◯ Outpatient Clinic ◯ Hospital

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

DAW: State-Specific Dispense as Written (DAW) Selection Verbiage:

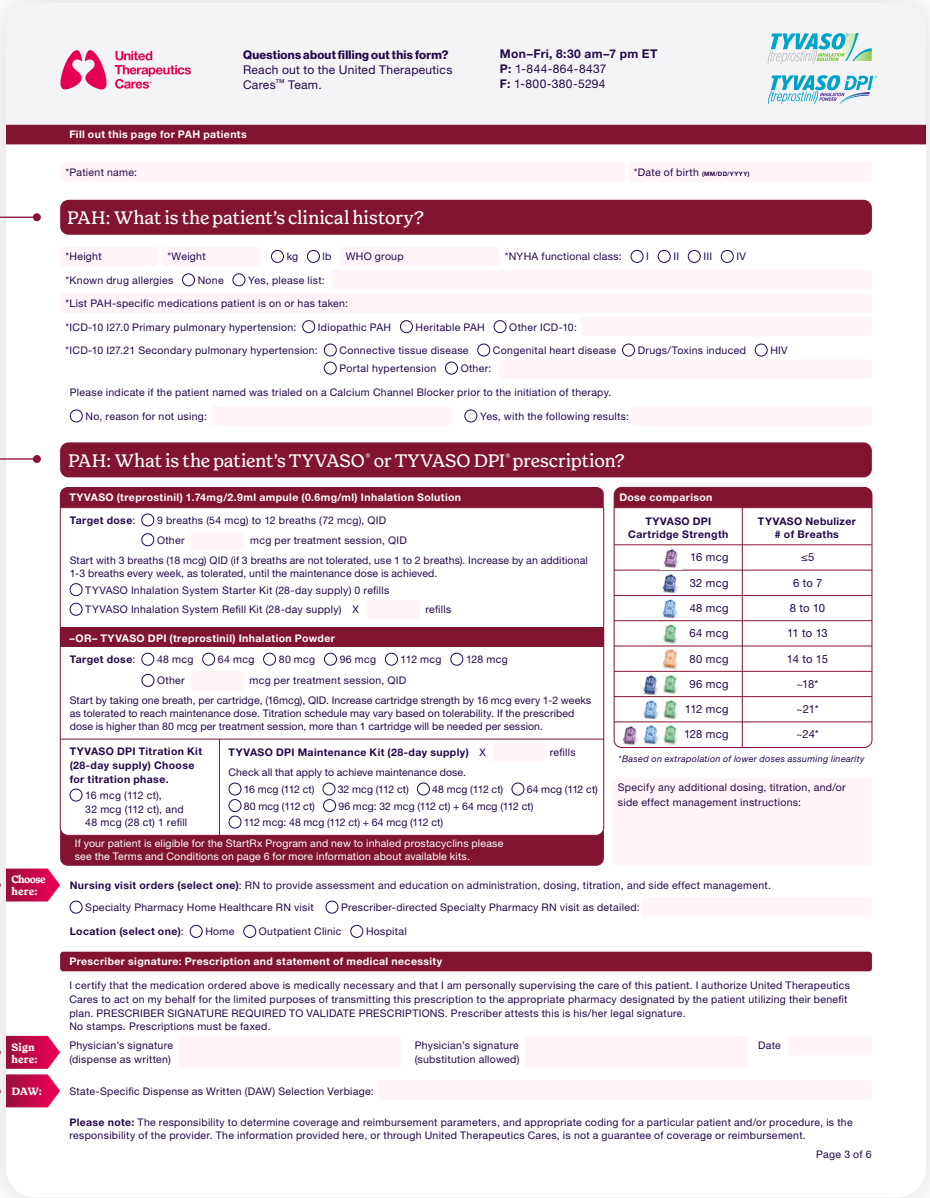
Please note: The responsibility to determine coverage and reimbursement parameters, and appropriate coding for a particular patient and/or procedure, is the responsibility of the provider. The information provided here, or through United Therapeutics Cares, is not a guarantee of coverage or reimbursement.

Page 2 of 6

ANNOTATED SAMPLE

TYVASO® (treprostinil) & TYVASO DPI® (treprostinil) Enrollment and Referral Form

Use this page for PAH patients



United Therapeutics Cares

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F: 1-800-380-5294

TYVASO (treprostinil) inhalation solution
TYVASO DPI (treprostinil) inhalation powder

Fill out this page for PAH patients

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

PAH: 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:

Please indicate if the patient named was trialed on a Calcium Channel Blocker prior to the initiation of therapy.

◯ No, reason for not using: ◯ Yes, with the following results:

PAH: What is the patient's TYVASO® or TYVASO DPI® prescription?

TYVASO (treprostinil) 1.74mg/2.9ml ampule (0.6mg/ml) Inhalation Solution

Target dose: ◯ 9 breaths (54 mcg) to 12 breaths (72 mcg), QID
◯ Other mcg per treatment session, QID

Start with 3 breaths (18 mcg) QID (if 3 breaths are not tolerated, use 1 to 2 breaths). Increase by an additional 1-3 breaths every week, as tolerated, until the maintenance dose is achieved.

◯ TYVASO Inhalation System Starter Kit (28-day supply) 0 refills
◯ TYVASO Inhalation System Refill Kit (28-day supply) X refills

–OR– TYVASO DPI (treprostinil) Inhalation Powder

Target dose: ◯ 48 mcg ◯ 64 mcg ◯ 80 mcg ◯ 96 mcg ◯ 112 mcg ◯ 128 mcg
◯ Other mcg per treatment session, QID

Start by taking one breath, per cartridge, (16mcg), QID. Increase cartridge strength by 16 mcg every 1-2 weeks as tolerated to reach maintenance dose. Titration schedule may vary based on tolerability. If the prescribed dose is higher than 80 mcg per treatment session, more than 1 cartridge will be needed per session.

TYVASO DPI Titration Kit (28-day supply) Choose for titration phase.
◯ 16 mcg (112 ct), 32 mcg (112 ct), and 48 mcg (28 ct) 1 refill

TYVASO DPI Maintenance Kit (28-day supply) X refills

Check all that apply to achieve maintenance dose.
◯ 16 mcg (112 ct) ◯ 32 mcg (112 ct) ◯ 48 mcg (112 ct) ◯ 64 mcg (112 ct)
◯ 80 mcg (112 ct) ◯ 96 mcg: 32 mcg (112 ct) + 64 mcg (112 ct)
◯ 112 mcg: 48 mcg (112 ct) + 64 mcg (112 ct)

If your patient is eligible for the StartRx Program and new to inhaled prostacyclins please see the Terms and Conditions on page 6 for more information about available kits.

Dose comparison

TYVASO DPI Cartridge Strength	TYVASO Nebulizer # of Breaths
16 mcg	≤5
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*Based on extrapolation of lower doses assuming linearity

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

Choose here:

Nursing visit orders (select one): RN to provide assessment and education on administration, dosing, titration, and side effect management.
◯ Specialty Pharmacy Home Healthcare RN visit ◯ Prescriber-directed Specialty Pharmacy RN visit as detailed:

Location (select one): ◯ Home ◯ Outpatient Clinic ◯ Hospital

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

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Page 3 of 6

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.

Insurance providers want to know if a patient was trialed on/showed a response to **a calcium channel blocker** (if they met criteria/are appropriate for CCB therapy) before treprostinil therapy.

For TYVASO Inhalation Solution

Select target dose and **note refills** for your patient to initiate and continue therapy.

For TYVASO DPI Inhalation Powder

1. Select **target dose**.
2. Select **Titration Kit** (if applicable).
3. Select all **Maintenance Kits** with refills noted if your patient will continue therapy.

For either prescription

Refer to the **comparison chart** of doses between TYVASO DPI and TYVASO Nebulizer.

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."

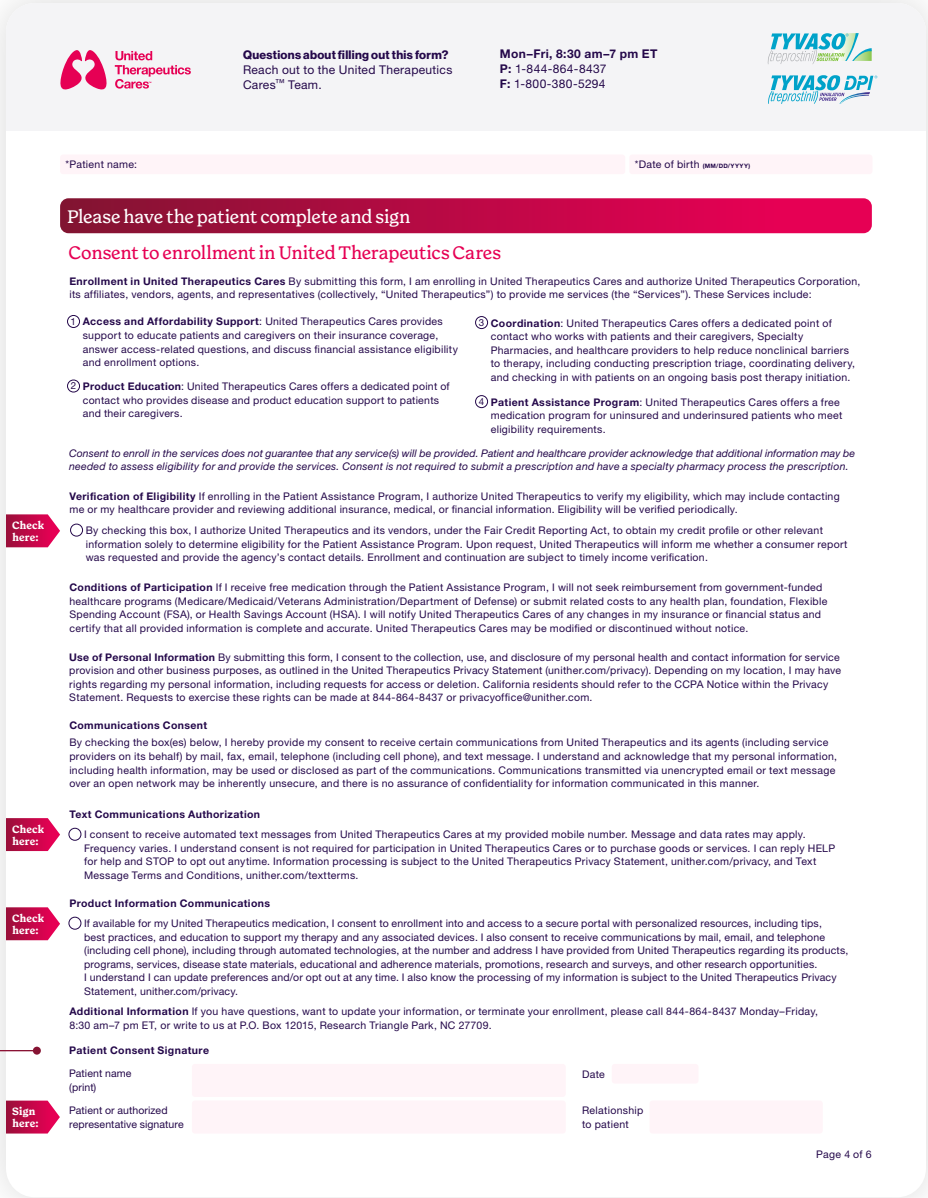
Select which **type of nurse visit** you would like your patient to receive. If necessary, provide additional details.

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

DAW **selection verbiage is required** for submission.

ANNOTATED SAMPLE

TYVASO® (treprostinil) & TYVASO DPI® (treprostinil) Enrollment and Referral Form



United Therapeutics Cares

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P: 1-844-864-8437
F: 1-800-380-5294

TYVASO (treprostinil)
TYVASO DPI (treprostinil) INHALATION POWDER

*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

Page 4 of 6

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.

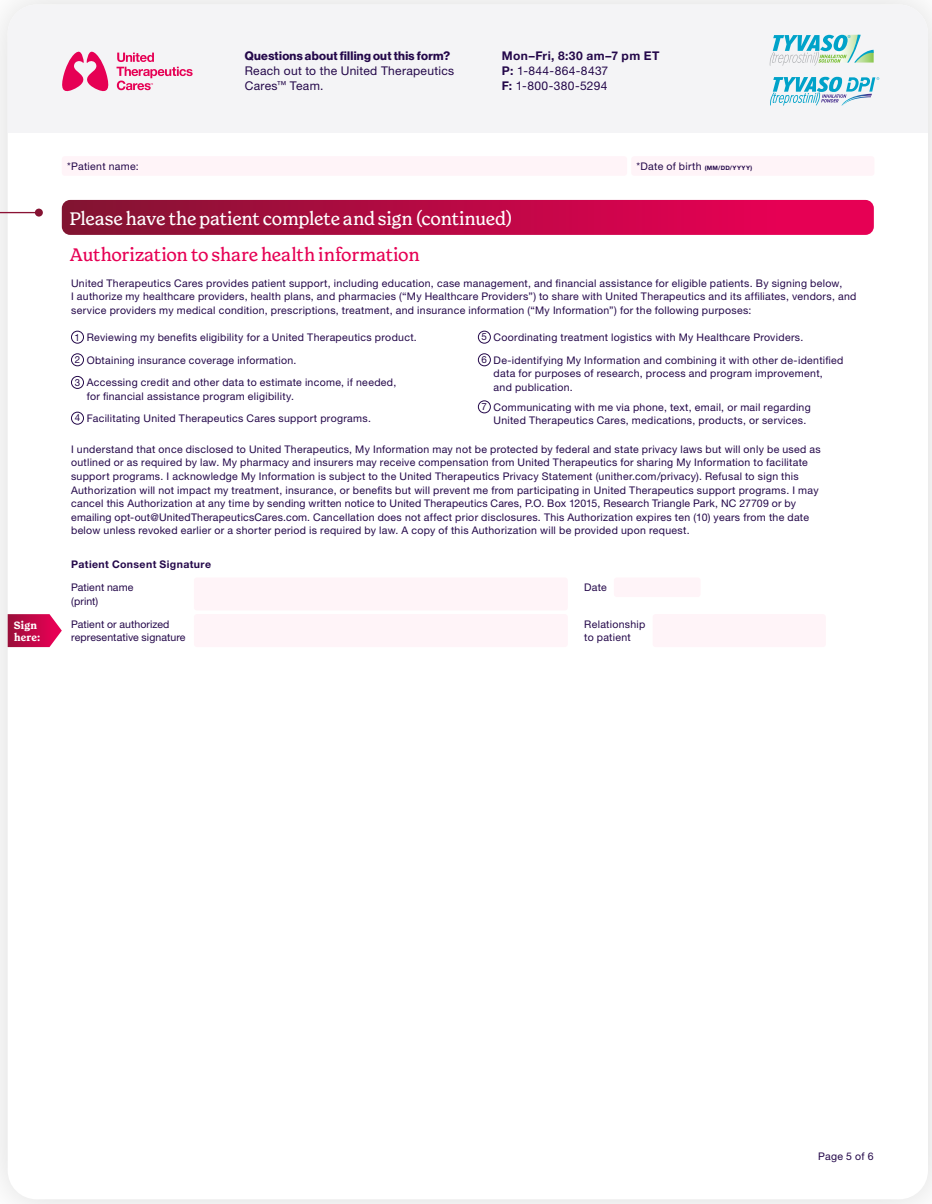
By checking this box, patients gain access to a personalized portal and additional therapy support education and resources from United Therapeutics.

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

ANNOTATED SAMPLE

TYVASO® (treprostinil) & TYVASO DPI® (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.



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TYVASO (treprostinil) INHALATION SOLUTION
TYVASO DPI (treprostinil) INHALATION POWDER

*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:

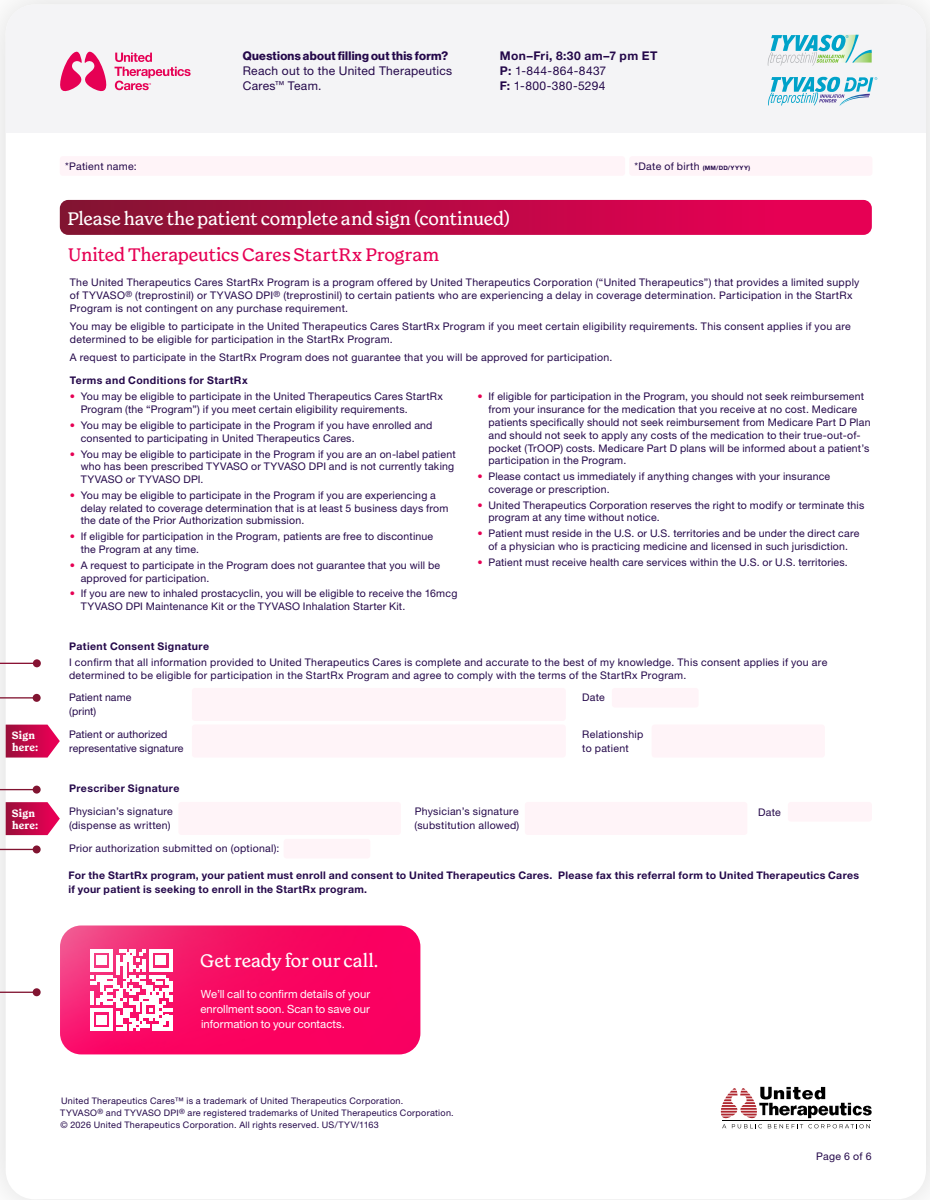
Patient or authorized representative signature

Relationship to patient

Page 5 of 6

ANNOTATED SAMPLE

TYVASO® (treprostinil) & TYVASO DPI® (treprostinil) Enrollment and Referral Form



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TYVASO (treprostinil) INHALATION SOLUTION
TYVASO DPI (treprostinil) INHALATION POWDER

*Patient name:

*Date of birth (MM/DD/YYYY)

Please have the patient complete and sign (continued)

United Therapeutics Cares StartRx Program

The United Therapeutics Cares StartRx Program is a program offered by United Therapeutics Corporation ("United Therapeutics") that provides a limited supply of TYVASO® (treprostinil) or TYVASO DPI® (treprostinil) to certain patients who are experiencing a delay in coverage determination. Participation in the StartRx Program is not contingent on any purchase requirement.

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

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

Terms and Conditions for StartRx

- You may be eligible to participate in the United Therapeutics Cares StartRx Program (the "Program") if you meet certain eligibility requirements.
- You may be eligible to participate in the Program if you have enrolled and consented to participating in United Therapeutics Cares.
- You may be eligible to participate in the Program if you are an on-label patient who has been prescribed TYVASO or TYVASO DPI and is not currently taking TYVASO or TYVASO DPI.
- You may be eligible to participate in the Program if you are experiencing a delay related to coverage determination that is at least 5 business 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 you are new to inhaled prostacyclin, you will be eligible to receive the 16mcg TYVASO DPI Maintenance Kit or the TYVASO Inhalation Starter Kit.
- 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.
- 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.

Patient Consent Signature

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 StartRx Program and agree to comply with the terms of the StartRx Program.

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):

For the StartRx program, your patient must enroll and consent to United Therapeutics Cares. Please fax this referral form to United Therapeutics Cares if your patient is seeking to enroll in the StartRx program.

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

By signing this form, patients are confirming their compliance with the terms of the StartRx program.

A patient's printed name, signature and the date are required to enroll and consent to the StartRx program.

Your **signature is required** to enroll your patient in the StartRx program.

If prior authorization was submitted, please write the date on which it was provided.

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

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

unitedtherapeuticscares.com

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