



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: <input type="radio"/> Orenitram® (treprostinil) <input type="radio"/> Remodulin® (treprostinil) <input type="radio"/> TYVASO® (treprostinil) <input type="radio"/> TYVASO DPI® (treprostinil)				Pages:
Preferred Speciality Pharmacy: <input type="radio"/> Accredo Health Group, Inc <input type="radio"/> CVS Specialty Pharmacy <i>To be used if patient's payer does not mandate a particular specialty pharmacy be used</i>				
Subject:				

Comments:

Important: This transmission contains confidential information that may be protected by state and federal laws. This transmission is intended for the exclusive use by United Therapeutics Corporation. If you are not the intended recipient you are hereby notified that any disclosure, dissemination, distribution, or copying of this information is strictly prohibited and may result in legal action. Please notify the sender by telephone at the number listed above to notify them if this was sent to you by mistake to arrange for the return or destruction of this information and all copies in your possession and to prevent recurrence.



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: <input type="radio"/> Male <input type="radio"/> Female	*Email	
*Home address		*City	*State
Shipping address (if different from home)		City	State
*Phone	<input type="radio"/> Personal <input type="radio"/> Work	Best time to call: <input type="radio"/> Morning <input type="radio"/> Afternoon <input type="radio"/> Evening	
OK to leave a message? <input type="radio"/> Yes <input type="radio"/> No		Primary language	
Caregiver/Family member name		Caregiver email	
Caregiver phone	<input type="radio"/> Personal <input type="radio"/> Work	Best time to call: <input type="radio"/> Morning <input type="radio"/> Afternoon <input type="radio"/> 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
*Office contact		*Phone	
Office contact email		*Fax	

What is the patient's insurance?

Primary prescription insurance		
Subscriber ID #	Group #	Phone
Primary medical insurance		
Subscriber ID #	Group #	Phone

Who is the preferred Specialty Pharmacy?

- Accredo Health Group, Inc. CVS Specialty Pharmacy

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.

Physician's signature (dispense as written) _____

Physician's signature (substitution allowed) _____

Date _____

Sign here:

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.

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.

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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.



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



*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.

- 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 insecure, and there is no assurance of confidentiality for information communicated in this manner.

Text Communications Authorization

- 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

- 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

Patient or authorized
representative signature

Relationship
to patient

Check here:

Check here:

Check here:

Sign here:

*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

Patient or authorized
representative signature

Relationship
to patient

Sign
here:

*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)	<input type="text"/>	Date	<input type="text"/>
Patient or authorized representative signature	<input type="text"/>	Relationship to patient	<input type="text"/>

Sign here:

Prescriber Signature

Physician’s signature (dispense as written)	<input type="text"/>	Physician’s signature (substitution allowed)	<input type="text"/>	Date	<input type="text"/>
Prior authorization submitted on (optional): <input type="text"/>					

Sign here:

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.