United Therapeutics REMODULIN (treprostinil) VA Referral Form

REMODULIN® (treprostinil) Injection

Prescriber: Please forward this completed form to the VA Pharmacy. The VA Pharmacy will fax the completed form to Accredo at Fax: 1-800-711-3526, Phone: 1-866-344-4874 or CVS Specialty at Fax: 1-877-943-1000, Phone: 1-877-242-2738.

Fill out the Patient and VA Pharmacy Information. Complete and sign the Prescriber Information, Prescription, and Statement of Medical Necessity. Let the patient know that an SPS provider will be calling, and that it is important to answer or return the call.

PATIENT INFORMATION

Name - First | Middle | Last

Date of Birth | Sex | Last 4 Digits of SSN

Home Address

City | State | Zip

Shipping Address (if different from home address)

City | State | Zip

Telephone: ☐ Home ☐ Cell ☐ Work | Alternate Telephone: ☐ Home ☐ Cell ☐ Work | Best Time(s) to Call: ☐ Morning ☐ Afternoon ☐ Evening

E-mail Address

Caregiver/Family Member | Caregiver E-mail Address

Caregiver Telephone: ☐ Home ☐ Cell ☐ Work | Caregiver Alternate Telephone: ☐ Home ☐ Cell ☐ Work | Okay to Leave a Message? ☐ Yes ☐ No

VA PHARMACY INFORMATION

Name of VA Facility

Address | Suite | City | State | Zip

Primary Purchasing Contact Name | Telephone | Fax | E-mail

Primary Clinical Contact Name | Telephone | Fax | E-mail

Secondary Purchasing Contact Name | Telephone | Fax | E-mail

Secondary Clinical Contact Name | Telephone | Fax | E-mail

Payment Method
☐ Credit Card (call pharmacy contact) ☐ E-invoice Tungsten Network

Purchase Order #

Ship to
☐ Patient ☐ VA Location

United Therapeutics CORPORATION

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Patient Name: _____ **Date of Birth:** _____

PRESCRIBER INFORMATION

Prescriber Name - First | Last | NPI # | State License #

Facility Name

Address | City

State | Zip | Telephone | Fax

E-mail Address

Office Contact Name | Office Contact Phone | Office Contact E-mail

Preferred Method of Communication ☐ Phone ☐ Email ☐ Mail ☐ Fax

REMODULIN PRESCRIPTION INFORMATION

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

Quantity: Dispense 1 month of drug and supplies X _____ refills **Patient dosing weight:** _____ ☐ kg ☐ lb

Infusion Type: ☐ Subcutaneous continuous infusion ☐ Intravenous continuous infusion

Pumps: ☐ CADD-MS® 3 Pumps (2) ☐ Ambulatory IV Infusion Pumps for Remodulin (2) ☐ Remunity® Pump for Remodulin (2) Patient Fill

The medication cost does not include the pump and supplies. Those are provided at an additional charge.

Dosing and Titration Instructions: To specify initial dosing and titration instructions, fill in the blanks **OR** use the lines below.

Initiation Dosage:_____ng/kg/min titrate _____ ng/kg/min every_____ days or at nearest cassette change until a goal dose of _____ng/kg/min is achieved.

Prescriber may specify any alternative or additional dosing and titration instructions here. For Remunity Pump System, titration is done at cassette change.

Specialty Pharmacy to contact prescribing practitioner for adjustments to the written orders specified above. Dose changes requiring a new vial strength may be required to be on the next shipment.

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

Check One (0.9% Sodium Chloride will be used if no box is checked): ☐ Remodulin Sterile Diluent for Injection ☐ pH 12 Sterile Diluent for Injection ☐ Epoprostenol Sterile Diluent for Injection ☐ 0.9% Sodium Chloride for Injection ☐ Sterile Water for Injection

The Prescriber is to comply with their state-specific prescription requirements such as the state-specific prescription form, fax language, etc. Non-compliance of state-specific requirements could result in outreach to the Prescriber.
Note: Order for this drug is not inclusive of skilled nursing home health services. To request skilled nursing services for home infusion therapy, the referring VA provider should enter a COMMUNITY CARE-GEC SKILLED HOME INFUSION therapy consult. The VA facility community care office will coordinate the requested service through CCN (Community Care Network) or VCA (Veteran Care Agreement) as appropriate.

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.
PHYSICIAN'S SIGNATURE REQUIRED TO VALIDATE PRESCRIPTIONS.

SIGN HERE

Physician's Signature: _____ _____ **Date:** _____
Dispense as Written **Substitution Allowed**

DAW

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

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

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