United Therapeutics Cares

REMODULIN® (treprostinil) Injection

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.

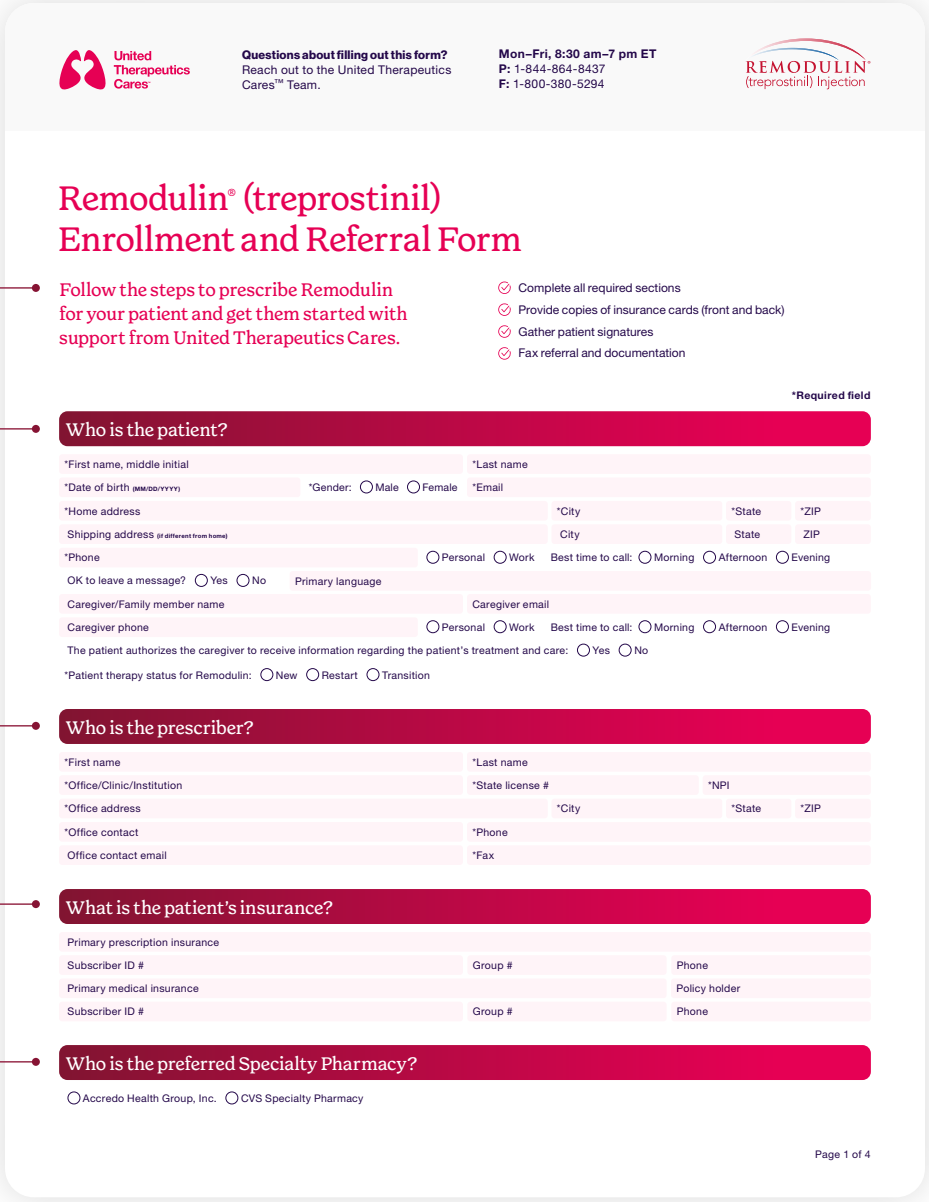
Use this checklist as a guide to complete the referral form.

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

REMODULIN® (treprostinil) Injection

Remodulin® (treprostinil) Enrollment and Referral Form

Follow the steps to prescribe Remodulin 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 Remodulin: ◯ 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

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Remodulin® (treprostinil) Enrollment and Referral Form

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REMODULIN® (treprostinil) Injection

*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:

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:

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.

What is the patient's Remodulin® prescription?

Infusion details	Vial concentrations
Quantity: Dispense 1 month of drug and supplies X time(s) refills Dosing Weight ◯ kg ◯ lb	◯ 0.4 mg/mL (20 mL vial)
Infusion type: ◯ Subcutaneous continuous infusion ◯ intravenous continuous infusion	◯ 1 mg/mL (20 mL vial)
Check one (0.9% Sodium Chloride will be used if no box is checked): ◯ Remodulin Sterile Diluent for Injection	◯ 2.5 mg/mL (20 mL vial)
◯ Epoprostenol Sterile Diluent for Injection ◯ 0.9% Sodium Chloride for Injection ◯ Sterile Water for Injection	◯ 5 mg/mL (20 mL vial)
Pumps: ◯ Ambulatory IV Infusion Pump (2)	◯ 10 mg/mL (20 mL vial)
◯ RemunityPRO™ Pump for Remodulin (Remunity Pumps (2), Remotes, Batteries + Chargers)	
Dosing and titration instructions	
To specify initial dosing and titration instructions, fill in the blanks OR use the lines below.	Specify any additional dosing, titration, and/or side effect management instructions:
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	

Provide dosing weight and **note refills** for your patient to initiate and continue therapy.

Select **infusion type**.

Select **preferred diluent** for intravenous delivery and **pump** for infusion.

Select **vial concentrations**.

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 weekly shipment.

Provide **dosing and titration instructions**.

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."

Choose here:

Nursing visit orders (select one): RN to provide assessment and education on administration, dosing, titration, and side effect management.

◯ **For IV infusions:**
Central venous catheter care: ◯ Dressing change every days ◯ Per IV standard of care

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

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

Select desired **nursing visit order and location**. If necessary, provide additional details.

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

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

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

DAW selection verbiage is required for submission.

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.

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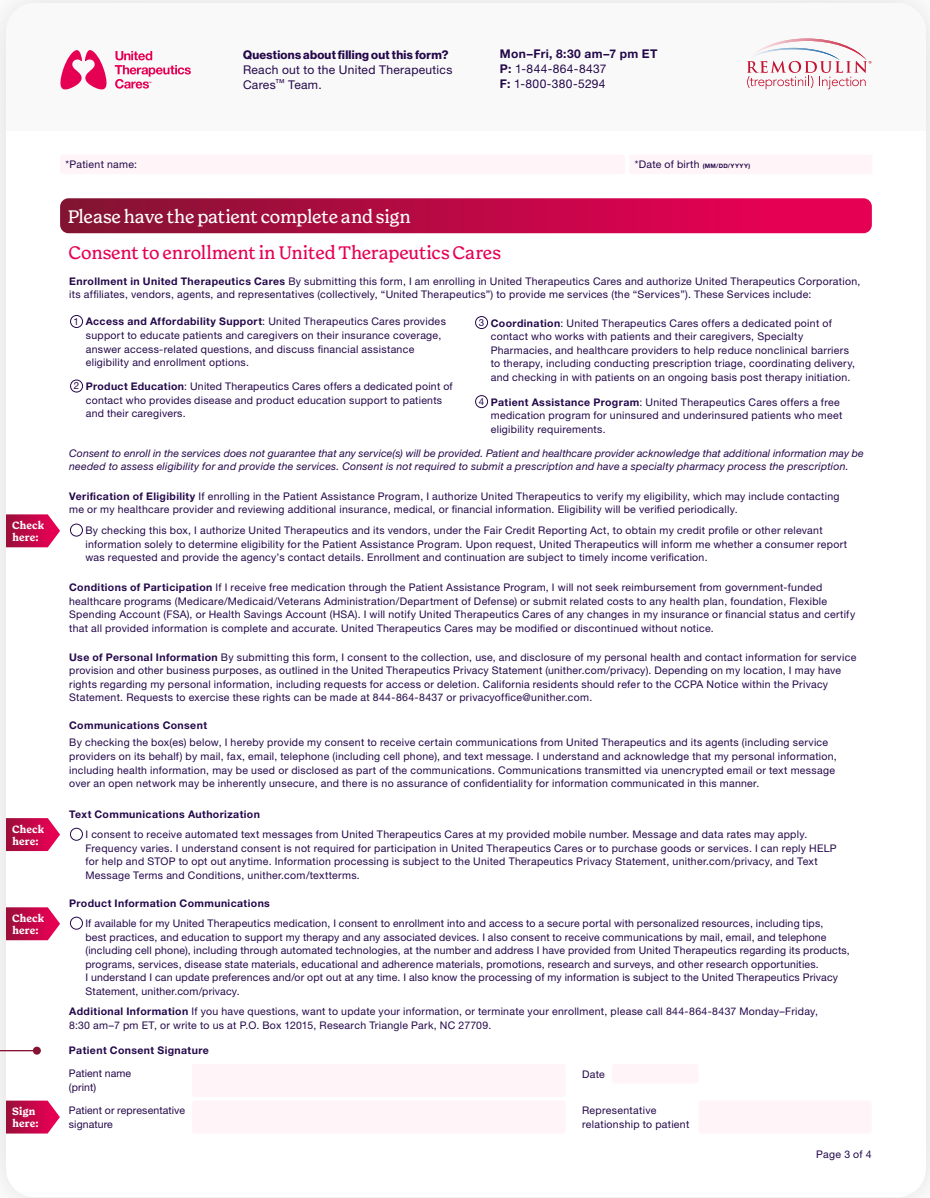
ANNOTATED SAMPLE

Remodulin® (treprostinil) Enrollment and Referral Form



United Therapeutics Cares

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F: 1-800-380-5294

REMODULIN® (treprostinil) Injection

*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

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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.

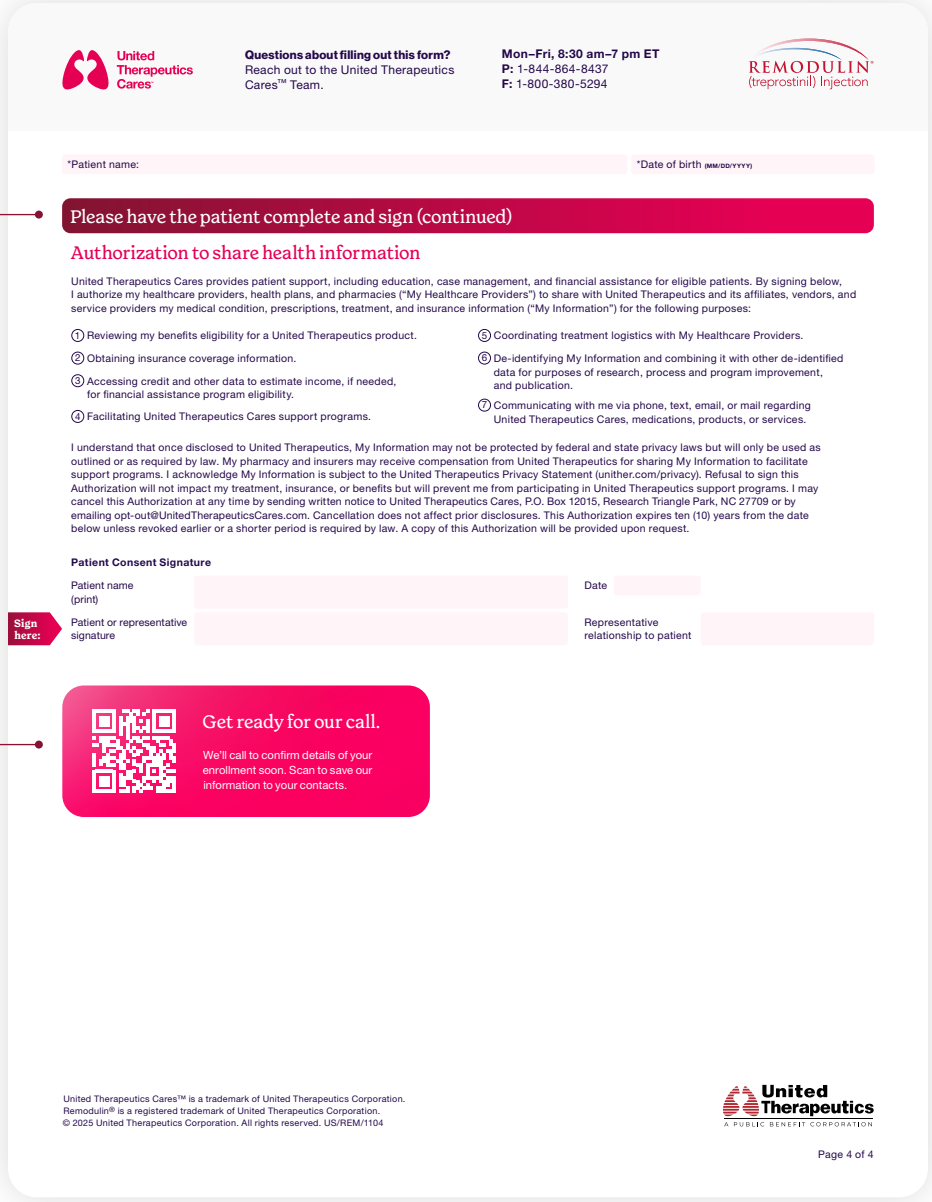
Your patient's printed name, signature, and the date are required to enroll in United Therapeutics Cares and receive Specialty Pharmacy services.

ANNOTATED SAMPLE

Remodulin® (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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REMODULIN® (treprostinil) Injection

*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 Cares™ is a trademark of United Therapeutics Corporation.
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United Therapeutics
A PUBLIC BENEFIT CORPORATION

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