

United Therapeutics Cares® Patient Authorization Form

Please return to United Therapeutics Cares by fax 1-800-380-5294 or mail to:
United Therapeutics, P.O. Box 12015, Research Triangle Park, NC 27709

Please include all required signatures and dates.
Call 1-844-864-8437 or visit [UnitedTherapeuticsCares.com](https://www.UnitedTherapeuticsCares.com)



Scan to Enroll or
Save Our Contact

***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
Shipping address (if different from home)		City	State
*Phone		Best time to call: ☐ Morning ☐ Afternoon ☐ Evening	
OK to leave a message? ☐ Yes ☐ No		Primary language	
Caregiver/Family member name		Caregiver email	
Caregiver phone		Best time to call: ☐ Morning ☐ Afternoon ☐ Evening	

The patient authorizes the caregiver to receive information regarding the patient's treatment and care.

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](https://www.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.

*Patient name:

*Date of birth (MM/DD/YYYY)

Please have the patient complete and sign (continued)

Consent to enrollment in United Therapeutics Cares

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

- ☐ 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 signatureRelationship
to patient

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 signatureRelationship
to patient

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 Patient Authorization Form

☒ Fax this cover sheet to 1-800-380-5294

To: United Therapeutics Cares	From:	Date:
Facility name:	Fax:	Phone:
Subject:		Pages:

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.