United Therapeutics Cares™

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: ◯ Orenitram® (treprostinil) ◯ Remodulin® (treprostinil) ◯ TYVASO® (treprostinil) ◯ TYVASO DPI® (treprostinil)		**Pages:**
Preferred speciality pharmacy: ◯ Accredo Health Group, Inc ◯ CVS Specialty Pharmacy *To be used if patient's payer does not mandate a particular specialty pharmacy be used*		
Subject:		

Comments:

United Therapeutics
A PUBLIC BENEFIT CORPORATION

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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.

*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) 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:

What is the patient's Remodulin® prescription?

Infusion details

Quantity: Dispense 1 month of drug and supplies X time(s) refills | Dosing Weight ◯ kg ◯ lb

Infusion type: ◯ Subcutaneous continuous infusion ◯ intravenous continuous infusion

Check one (0.9% Sodium Chloride will be used if no box is checked): ◯ Remodulin Sterile Diluent for Injection ◯ Epoprostenol Sterile Diluent for Injection ◯ 0.9% Sodium Chloride for Injection ◯ Sterile Water for Injection

Pumps: ◯ Ambulatory IV Infusion Pump (2)
◯ RemunityPRO™ Pump for Remodulin (Remunity Pumps (2), Remotes, Batteries + Chargers)

Vial concentrations

◯ 0.4 mg/mL (20 mL vial)
◯ 1 mg/mL (20 mL vial)
◯ 2.5 mg/mL (20 mL vial)
◯ 5 mg/mL (20 mL vial)
◯ 10 mg/mL (20 mL vial)

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

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

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.

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

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.

The Prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax lanugage, etc.

Sign here:

Dispense as Written:
Brand Medically Necessary/Do Not Substitute/No Substitution/May Not Substitute

Physician's signature | Date

OR

May Substitute:
Product Selection Permitted/Substitution Permissible

Physician's signature | Date

*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

*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

Get ready for our call.

We'll call to confirm details of your enrollment soon. Scan to save our information to your contacts.

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