United Therapeutics Cares™ Patient Authorization Form

Please return this application 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.
Call 1-844-864-8437 or visit UnitedTherapeuticsCares.com

United Therapeutics Cares™

1 PATIENT INFORMATION

Name - First | Middle | Last

Date of Birth | Gender | SSN

Home Address | Do you reside in the United States? ☐ Yes ☐ No

City | State | Zip

Shipping Address (if different from home address)

City | State | Zip

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

Okay to leave a voicemail? ☐ Yes ☐ No

E-mail Address

Caregiver/Family Member | Caregiver Telephone: ☐ Home ☐ Cell ☐ Work | Caregiver Alternate Telephone: ☐ Home ☐ Cell ☐ Work

Caregiver E-mail Address | Caregiver Alternate E-mail Address | Okay to leave a voicemail? ☐ Yes ☐ No

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.

2 PATIENT CONSENT

Enrolling in United Therapeutics Cares. By submitting this form, I am enrolling in **United Therapeutics Cares**, and I authorize United Therapeutics Corporation, its affiliated companies, vendors, agents, and representatives (collectively, "United Therapeutics") to provide me services through United Therapeutics Cares. Such services, as described on Page 1, include: **(1)** Access and Affordability Support, through which United Therapeutics Cares will provide 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, through which United Therapeutics Cares offers a dedicated point of contact, who provides disease and product education support to patients and their caregivers; **(3)** Coordination, through which United Therapeutics Cares offers a dedicated point of contact who works with patients and their caregivers, specialty pharmacies and healthcare providers to help reduce non-clinical barriers to therapy, including conducting prescription triage, coordinating delivery, and checking in with patients on an ongoing basis post therapy initiation; and **(4)** United Therapeutics Cares Patient Assistance Program, which offers a free medication program for uninsured and underinsured patients who meet eligibility requirements (the "Services").

Verification of Eligibility. To the extent I am enrolling in the United Therapeutics Cares Patient Assistance Program, I authorize United Therapeutics to verify my eligibility for the Patient Assistance Program, and I understand that such verification may include contacting me or my healthcare provider for additional information and/or reviewing additional insurance, medical information and/or financial information. I understand that eligibility for participation will be verified periodically.

CHECK HERE ☐ By checking this box, I am providing written instructions authorizing United Therapeutics Cares, United Therapeutics and their vendors, under the Fair Credit Reporting Act to obtain information about my credit profile or other information from credit reporting agencies or public or other sources. I authorize United Therapeutics Cares to obtain such information solely to determine eligibility for enrollment in the United Therapeutics Cares Patient Assistance Program. I understand that such reports may contain information about my income, credit standing, credit worthiness, credit capacity, character or personal characteristics. I understand that, upon request, United Therapeutics will tell me whether an individual consumer report was requested and the name and address of the agency that furnished it. Enrollment and continuation in the United Therapeutics Cares Patient Assistance Program are conditioned upon timely verification of income.

Conditions of Participation. If I receive free drugs under the United Therapeutics Cares Patient Assistance Program, I certify that I will not seek payment for the United Therapeutics product from any government-funded healthcare program (Medicare/Medicaid/Veterans Administration/Department of Defense), and that I will not submit any costs paid by United Therapeutics Cares as a claim for payment to a health plan, foundation, flexible spending account, or healthcare savings account. I agree to notify United Therapeutics Cares if my insurance or financial situation changes. I certify that any information, including financial and insurance information I provide, is complete and true. I understand that United Therapeutics Cares may be changed or discontinued without notice.

Use of Personal Information. I understand through my submission of this Patient Enrollment and Referral Form, I consent to the collection, use and disclosure of my personal health data, contact information and other identifying information by United Therapeutics for provision of the Services and for other business purposes, as described in the United Therapeutics Privacy Statement, available at: **www.unither.com/privacy**. Depending on where I live, I may have certain rights with respect to the privacy of my information, including the request to access or delete my personal information, as described in the United Therapeutics

United Therapeutics
A PUBLIC BENEFIT CORPORATION

United Therapeutics Cares™ Patient Authorization Form

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

Privacy Statement. If you are a California resident, please see our CCPA Notice at Collection provided within the United Therapeutics Privacy Statement. I am aware that United Therapeutics may not be required to fulfill my requests in certain circumstances. I understand that to exercise these rights, I may contact United Therapeutics at 844-864-8437 or privacyoffice@unither.com.

Communications. 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.

UNITED THERAPEUTICS CARES TEXT COMMUNICATIONS AUTHORIZATION

CHECK HERE ☐ Yes, I consent to receive automated text messages from "United Therapeutics Cares" at the mobile phone number I have provided. Message and data rates may apply. Message frequency varies. I understand I am not required to consent to receive text messages to participate in United Therapeutics Cares, to purchase any goods or services, or to receive any other communications I have selected. I can reply HELP for help. I can reply STOP to opt out at any time. I understand the processing of my information is subject to the United Therapeutics Privacy Statement, www.unither.com/privacy, and Text Message Terms and Conditions, www.unither.com/textterms.

MARKETING AUTHORIZATION

CHECK HERE ☐ Yes, I 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 the processing of my information is subject to the United Therapeutics Privacy Statement, www.unither.com/privacy.

Additional Information. Additional information on United Therapeutics Cares can be found on our website at www.UnitedTherapeuticsCares.com. If you have questions, want to update your information, or terminate your enrollment, please call 844-864-8437 Monday–Friday, 8:30 am–7:00 pm ET or write to us at P.O. Box 12015 Research Triangle Park, NC 27709.

2 PATIENT CONSENT SIGNATURE

Patient Name (Print): _____ **Date:** _____

SIGN HERE **Patient or Representative Signature:** _____

Representative relationship to patient if patient cannot sign: _____

3 PATIENT AUTHORIZATION TO SHARE HEALTH INFORMATION

United Therapeutics Corporation ("United Therapeutics") offers United Therapeutics Cares, which provides patient support services including educational resources, case management support, and financial assistance for eligible patients. By signing below, I give my permission for my healthcare providers, health plans, pharmacies, and other healthcare service providers ("My Healthcare Providers") to share with United Therapeutics, its present and future affiliates, vendors, and other companies, entities, and individuals working with and on behalf of United Therapeutics, personal information relating to my medical condition, prescriptions, treatment and health insurance information ("My Information") so that United Therapeutics may: **1)** review my eligibility for benefits for treatment with a United Therapeutics product; **2)** obtain information on insurance coverage for my treatment; **3)** access my credit information and information from other sources to estimate my income, if needed, to assess eligibility for financial assistance programs; **4)** facilitate and manage United Therapeutics Cares; **5)** coordinate treatment logistics with My Healthcare Providers; **6)** de-identify My Information and combine it with other de-identified data for purposes of research, process and program improvement, and publication; and **7)** communicate with me by telephone (including cell phone), text message, email, mail or fax regarding United Therapeutics Cares, United Therapeutics medications, products or services for the purposes set forth below, if I provide my consent.

I understand that once My Information has been disclosed to United Therapeutics pursuant to this Authorization, it may no longer be protected by federal and state privacy laws from further disclosure. I also understand however that United Therapeutics intends to use and disclose My Information only for purposes stated in this Authorization or as required by law. I understand that my pharmacy and health insurers may receive remuneration (payment) from United Therapeutics in exchange for sharing My Information with United Therapeutics to facilitate the patient support programs and other purposes described in this Authorization. I understand that My Information is also subject to the United Therapeutics Privacy Statement available at **www.unither.com/privacy**. **I understand that I may refuse to sign this Authorization, and that refusing will not affect my treatment, insurance enrollment, or eligibility for insurance benefits, but it will make me ineligible to participate in United Therapeutics' support programs.** If I do sign, I may cancel this Authorization at any time by mailing a letter to: United Therapeutics Cares, P.O. Box 12015 Research Triangle Park, NC 27709 or by emailing opt-out@unitedtherapeuticscares.com. I understand that canceling this Authorization will not invalidate reliance on this Authorization to use or disclose My Information prior to United Therapeutics' receipt of my notice of cancellation. This Authorization expires ten (10) years from the date next to my signature, unless I revoke it sooner, or unless a shorter timeframe is required by applicable law. I understand I have a right to receive a copy of this Authorization after it is signed.

3 PATIENT AUTHORIZATION SIGNATURE

Patient Name (Print): _____ **Date:** _____

SIGN HERE **Patient or Representative Signature:** _____

Representative relationship to patient if patient cannot sign: _____

United Therapeutics Cares™ Patient Authorization Form

4 FAX COVER SHEET

Date: _____

To: United Therapeutics Cares™

Fax Number 1-800-380-5294
Phone Number 1-844-864-8437

From: _____

Facility Name: _____

Fax: _____

Included in this fax:

☐ **Completed and signed United Therapeutics Cares Patient Authorization Form**

- Step 1 - Patient and Insurance Information (including front and back copies of medical and prescription insurance card(s))
- Step 2 - Patient Consent
- Step 3 - Patient Authorization

Number of Pages: _____

Additional Comments:

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US-PTR-0044
Patient documents may be mailed to: United Therapeutics, P.O. Box 12015, Research Triangle Park, NC 27709

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