United Therapeutics Cares™

Hospital to Home 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

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

TYVASO® (treprostinil) INHALATION SOLUTION
TYVASO DPI® (treprostinil) INHALATION POWDER

HOSPITAL TO HOME

TYVASO® (treprostinil) & TYVASO DPI® (treprostinil) Enrollment and Referral Form

Follow the steps to prescribe TYVASO or TYVASO DPI 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**

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 **TYVASO**: ◯ New ◯ Restart ◯ Transition

*Patient therapy status for **TYVASO DPI**: ◯ 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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TYVASO® (treprostinil) INHALATION SOLUTION
TYVASO DPI® (treprostinil) INHALATION POWDER

Fill out this page for PH-ILD patients

*Patient name: *Date of birth (MM/DD/YYYY)

PH-ILD: 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:

***PH Diagnosis Codes (choose one):**

ICD-10 I27.23: ◯ Pulmonary hypertension due to lung diseases and hypoxia ◯ Other ICD-10:

***ILD Diagnosis Codes (choose one):**

IIP: ICD-10 J84.10: ◯ Pulmonary fibrosis, unspecified ICD-10 J84.111: ◯ Idiopathic interstitial pneumonia, NOS ICD-10 J84.112: ◯ Idiopathic pulmonary fibrosis

CTD-related ILD: ICD-10 M34.81: ◯ Systemic sclerosis with lung involvement

Environmental/Occupational Lung Disease: ICD-10 J61: ◯ Pneumoconiosis due to asbestos and other mineral fibers

ICD-10 J67.9: ◯ Hypersensitivity pneumonitis due to unspecified dust

Other causes: ICD-10 J17: ◯ Pneumonia in disease classified elsewhere ◯ Other ICD-10:

PH-ILD: What is the patient's TYVASO® or TYVASO DPI® prescription?

TYVASO (treprostinil) 1.74mg/2.9ml ampule (0.6mg/ml) Inhalation Solution

Target dose: ◯ 9 breaths (54 mcg) to 12 breaths (72 mcg), QID

◯ Other mcg per treatment session, QID

Start with 3 breaths (18 mcg) QID (if 3 breaths are not tolerated, use 1 to 2 breaths). Increase by an additional 1-3 breaths every week, as tolerated, until the maintenance dose is achieved.

◯ TYVASO Inhalation System Starter Kit (28-day supply) 0 refills

◯ TYVASO Inhalation System Refill Kit (28-day supply) X refills

–OR– TYVASO DPI (treprostinil) Inhalation Powder

Target dose: ◯ 48 mcg ◯ 64 mcg ◯ 80 mcg ◯ 96 mcg ◯ 112 mcg ◯ 128 mcg

◯ Other mcg per treatment session, QID

Start by taking one breath, per cartridge, (16mcg), QID. Increase cartridge strength by 16 mcg every 1-2 weeks as tolerated to reach maintenance dose. Titration schedule may vary based on tolerability. If the prescribed dose is higher than 80 mcg per treatment session, more than 1 cartridge will be needed per session.

TYVASO DPI Titration Kit (28-day supply) Choose for titration phase.

◯ 16 mcg (112 ct), 32 mcg (112 ct), and 48 mcg (28 ct) 1 refill

TYVASO DPI Maintenance Kit (28-day supply) X refills

Check all that apply to achieve maintenance dose.

◯ 16 mcg (112 ct) ◯ 32 mcg (112 ct) ◯ 48 mcg (112 ct) ◯ 64 mcg (112 ct)
◯ 80 mcg (112 ct) ◯ 96 mcg: 32 mcg (112 ct) + 64 mcg (112 ct)
◯ 112 mcg: 48 mcg (112 ct) + 64 mcg (112 ct)

Dose comparison

TYVASO DPI Cartridge Strength	TYVASO Nebulizer # of Breaths
16 mcg	≤5
32 mcg	6 to 7
48 mcg	8 to 10
64 mcg	11 to 13
80 mcg	14 to 15
96 mcg	~18*
112 mcg	~21*
128 mcg	~24*

Based on extrapolation of lower doses assuming linearity

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

Choose here:

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

◯ Specialty Pharmacy Home Healthcare RN visit ◯ Prescriber-directed Specialty Pharmacy RN visit 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.

Sign here:

Physician's signature (dispense as written) Physician's signature (substitution allowed) Date

DAW:

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

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.

United Therapeutics Cares®

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TYVASO® (treprostinil) INHALATION SOLUTION
TYVASO DPI® (treprostinil) INHALATION POWDER

Fill out this page for PAH patients

*Patient name: | *Date of birth (MM/DD/YYYY)

PAH: 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:

PAH: What is the patient's TYVASO® or TYVASO DPI® prescription?

TYVASO (treprostinil) 1.74mg/2.9ml ampule (0.6mg/ml) Inhalation Solution

Target dose: ◯ 9 breaths (54 mcg) to 12 breaths (72 mcg), QID
◯ Other mcg per treatment session, QID

Start with 3 breaths (18 mcg) QID (if 3 breaths are not tolerated, use 1 to 2 breaths). Increase by an additional 1-3 breaths every week, as tolerated, until the maintenance dose is achieved.

◯ TYVASO Inhalation System Starter Kit (28-day supply) 0 refills
◯ TYVASO Inhalation System Refill Kit (28-day supply) X refills

–OR– TYVASO DPI (treprostinil) Inhalation Powder

Target dose: ◯ 48 mcg ◯ 64 mcg ◯ 80 mcg ◯ 96 mcg ◯ 112 mcg ◯ 128 mcg
◯ Other mcg per treatment session, QID

Start by taking one breath, per cartridge, (16mcg), QID. Increase cartridge strength by 16 mcg every 1-2 weeks as tolerated to reach maintenance dose. Titration schedule may vary based on tolerability. If the prescribed dose is higher than 80 mcg per treatment session, more than 1 cartridge will be needed per session.

TYVASO DPI Titration Kit (28-day supply) Choose for titration phase.
◯ 16 mcg (112 ct), 32 mcg (112 ct), and 48 mcg (28 ct) 1 refill

TYVASO DPI Maintenance Kit (28-day supply) X refills
Check all that apply to achieve maintenance dose.
◯ 16 mcg (112 ct) ◯ 32 mcg (112 ct) ◯ 48 mcg (112 ct) ◯ 64 mcg (112 ct)
◯ 80 mcg (112 ct) ◯ 96 mcg: 32 mcg (112 ct) + 64 mcg (112 ct)
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Dose comparison

TYVASO DPI Cartridge Strength	TYVASO Nebulizer # of Breaths
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Based on extrapolation of lower doses assuming linearity

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

Choose here:

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

◯ Specialty Pharmacy Home Healthcare RN visit ◯ Prescriber-directed Specialty Pharmacy RN visit as detailed:

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

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No stamps. Prescriptions must be faxed.

Sign here:

Physician's signature (dispense as written) | Physician's signature (substitution allowed) | Date

DAW:

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

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*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

*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

*Patient name:

*Date of birth (MM/DD/YYYY)

Please have the patient complete and sign (continued)

United Therapeutics Cares Hospital to Home Program

The United Therapeutics Cares Hospital to Home Program is a program offered by United Therapeutics Corporation ("United Therapeutics") that provides a limited supply of TYVASO® (treprostinil) or TYVASO DPI® (treprostinil) to certain patients who have initiated TYVASO (treprostinil) or TYVASO DPI (treprostinil) in a hospital setting and who are experiencing a delay in coverage determination.

You may be eligible to participate in the United Therapeutics Cares Hospital to Home Program if you meet certain eligibility requirements. This consent applies if you are determined to be eligible for participation in the Hospital to Home Program.

A request to participate in the Hospital to Home Program does not guarantee that you will be approved for participation.

Terms and Conditions for Hospital to Home

- You may be eligible to participate in the United Therapeutics Cares Hospital to Home Program (the "Program") if you meet certain eligibility requirements.
- You may be eligible to participate in the Program if you have enrolled and consented to participating in United Therapeutics Cares.
- You may be eligible to participate in the Program if you are an on-label patient in the hospital who is currently on TYVASO or TYVASO DPI.
- If eligible for participation in the Program, patients are free to discontinue the Program at any time.
- If eligible for participation in the Program, you should not seek reimbursement from your insurance for the medication that you receive at no cost. Medicare patients specifically should not seek reimbursement from Medicare Part D Plan and should not seek to apply any costs of the medication to their true-out-of-pocket (TrOOP) costs. Medicare Part D plans will be informed about a patient's participation in the Program.
- You may be eligible to participate in the Program if you are experiencing a delay related to coverage determination that is at least 3 days from the date of the Prior Authorization submission.
- A request to participate in the Program does not guarantee that you will be approved for participation.
- Please contact us immediately if anything changes with your insurance coverage or prescription.
- United Therapeutics Corporation reserves the right to modify or terminate this program at any time without notice.
- Patient must reside in the U.S. or U.S. territories and be under the direct care of a physician who is practicing medicine and licensed in such jurisdiction.
- Patient must receive health care services within the U.S. or U.S. territories.

Please acknowledge and confirm the following:

◯ I acknowledge that I have initiated TYVASO (treprostinil) or TYVASO DPI (treprostinil) within a hospital setting.

◯ I confirm that all information provided to United Therapeutics Cares is complete and accurate to the best of my knowledge. This consent applies if you are determined to be eligible for participation in the Hospital to Home Program and agree to comply with the terms of the Hospital to Home Program.

◯ Date of therapy initiation in hospital (optional):

◯ Prior authorization submitted on (optional):

Patient Consent Signature

Patient name (print)

Date

Sign here: Patient or representative signature

Representative relationship to patient

Prescriber Signature

Sign here: Physician's signature (dispense as written)

Physician's signature (substitution allowed)

Date

For the Hospital to Home program, your patient must enroll and consent to United Therapeutics Cares. Please fax this referral form to United Therapeutics Cares if your patient is seeking to enroll in the Hospital to Home program.

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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