Yutrepia™ (treprostinil) inhalation powder

ENROLLMENT FORM

YUTREPIA™ (treprostinil) inhalation powder is available through select specialty pharmacy (SP) providers.

INSTRUCTIONS:

- **Complete all relevant sections on page 1.** Inform your patient their SP will call to process their Rx.
- **Complete the Standard Rx (pages 2 and 3) or the Voucher Rx (pages 3 and 4).** If only a Voucher Rx is submitted, a Standard Rx will be needed at a later date if you and your patient wish to continue therapy beyond the initial 28-day voucher period.
- If needed, **complete the Voucher in-hospital URGENT start request (page 5)**.
- **Fax the form and signed supporting documents** to your selected SP (cover sheet provided).

PATIENT INFORMATION

Patient Name (first, MI, last)

Email

HOME ADDRESS

Phone ☐ Home ☐ Cell ☐ Work

Alternate Phone ☐ Home ☐ Cell ☐ Work

City | State | Zip

Preferred contact: ◯ Phone ◯ Email

Best time to call: ◯ Morning ◯ Afternoon ◯ Night

Date of Birth (mm/dd/yyyy)

Gender: ◯ Male ◯ Female

Preferred language:

CAREGIVER Name

Caregiver Phone ☐ Home ☐ Cell ☐ Work

Alternate Phone ☐ Home ☐ Cell ☐ Work

Caregiver Email

Preferred contact: ◯ Phone ◯ Email

Best time to call: ◯ Morning ◯ Afternoon ◯ Night

PRESCRIBER INFORMATION

Prescriber Name (first, MI, last)

NPI # | State License # | Tax ID #

Office / Clinic / Institution Name

Office Contact Name

Address

Office Contact Email

City | State | Zip

Phone | Fax

Preferred method of communication: ◯ Phone ◯ Email ◯ Fax

INSURANCE INFORMATION

(Not required if only requesting a Voucher Prescription on page 4)

Pharmacy Benefits Manager

Please include copies of the front and back of all patient's medical and prescription insurance cards.

PRIMARY Medical Insurance Carrier

SECONDARY Medical Insurance Carrier

Policyholder Name

Policyholder Name

Policy ID Number | Group Number (if applicable)

Policy ID Number | Group Number (if applicable)

Medical Insurance Phone | Relationship to Policyholder

Medical Insurance Phone | Relationship to Policyholder

Liquidia™

Patient Name (first, MI, last) | Date of Birth

Standard Prescription

STANDARD PRESCRIPTION INFORMATION

YUTREPIA™ (treprostinil) inhalation powder

Starting Dose: _____mcg **Target Dose:** _____mcg

Dispense:
28-day supply, 1-year refills **OR** ◯ _____ day supply, _____ refills

Frequency:
Two (2) breaths per capsule, four (4) times daily **OR**
◯ Two (2) breaths per capsule, _____ times daily

Titration (as tolerated, to target dose):
Increase by 26.5 mcg every week. or as tolerated, **OR**
◯ Increase by _____ mcg, every _____ ☐ week(s) / ☐ days

NDC(s) Prescribed	Included NDCs in this prescription:	
SP will dispense the prescribed dose per needed NDC combinations.	26.5 mcg	(72964-011-01)
	53 mcg	(72964-012-01)
	79.5 mcg	(72964-013-01)
	106 mcg	(72964-014-01)

DOSE COMPARISON

Tyvaso® (Nebulized) QID Breaths	YUTREPIA™ QID Dose (mcg)	YUTREPIA™ Capsule Combination (mcg)
≤5	26.5	26.5
≥6 and ≤8	53	53
≥9 and ≤11	79.5	79.5
≥12 and ≤14	106	106
≥15 and ≤17	132.5	53 + 79.5
~18	159	79.5 + 79.5
~21	185.5	79.5 + 106
~24	212	106 + 106

SP will confirm NDC combinations needed to meet prescribed dose.

NURSING ORDERS

SP home health nurse visit(s) to teach and assess the self-administration of YUTREPIA, including dosing, titration, and side effect management.

◯ Decline Nursing Services

STATEMENT OF MEDICAL NECESSITY

I certify that the therapy ordered above is medically necessary and that I am personally supervising the care of this patient.

Prescriber Full Name (print)

SIGN HERE

Dispense As Written (DAW) / Brand Medically Necessary / No Substitution / May Not Substitute / Do Not Substitute

Prescriber Signature*

Substitution Permitted / May Substitute / Product Selection Permitted

Prescriber Signature*

Date

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution": _____

ATTN: New York and Iowa providers, please submit electronic prescription.

*Prescriber attests that this is his/her legal signature.

NO STAMPS. PRESCRIPTIONS MUST BE FAXED.

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 is not a guarantee of coverage or reimbursement.

Patient Name (first, MI, last) | Date of Birth

PATIENT EVALUATION

Patient Status:
- ◯ Outpatient
- ◯ Inpatient

YUTREPIA™ Status:
- ◯ Naïve / New
- ◯ Restart
- ◯ Transition

WHO Group:
- ◯ Group 1 (PAH)
- ◯ Group 3 (PH-ILD)
- ◯ Groups 1 and 3

Allergies:
- ◯ No known drug allergies (NKDA)
- ◯ Yes (specify):

Current Medications (list all):

TRANSITION STATEMENT

(if applicable)

It is necessary for this patient to transition

from:

to:

Please provide justification for this transition.

MEDICAL INFORMATION

Please select the relevant ICD-10 codes below or enter a different one if needed. Listed codes do not imply approval, coverage, or reimbursement for specific uses or indications.

PAH **ICD-10 I27.0 Primary pulmonary hypertension**
- ◯ Idiopathic PAH
- ◯ Heritable PAH

ICD-10 I27.21 Secondary pulmonary arterial hypertension
- ◯ Connective tissue disease
- ◯ Congenital heart disease
- ◯ Drugs/Toxins induced
- ◯ Portal hypertension
- ◯ HIV
- ◯ **Other ICD-10:** _____ Code _____ Description

PH
- ◯ **ICD-10 I27.23 Pulmonary hypertension due to lung diseases and hypoxia**
- ◯ **Other ICD-10:** _____ Code _____ Description

ILD **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

TREATMENT HISTORY

Please indicate treatment history

Adempas® (riociguat) Tablets	◯ Current	◯ Discontinued
Flolan® (epoprostenol sodium) for Injection	◯ Current	◯ Discontinued
Letairis® (ambrisentan) Tablets	◯ Current	◯ Discontinued
Opsumit® (macitentan) Tablets	◯ Current	◯ Discontinued
Opsynvi® (macitentan/tadalafil)	◯ Current	◯ Discontinued
Orenitram® (treprostinil) Extended-Release Tablets	◯ Current	◯ Discontinued
PDE-5i (specify drugs): _____	◯ Current	◯ Discontinued
Remodulin® (treprostinil) Injection	◯ Current	◯ Discontinued
Tracleer® (bosentan) Tablets	◯ Current	◯ Discontinued
Tyvaso® (treprostinil) Inhalation Solution	◯ Current	◯ Discontinued
Tyvaso DPI® (treprostinil) Inhalation Powder	◯ Current	◯ Discontinued
Uptravi® (selexipag) Tablets	◯ Current	◯ Discontinued
Veletri® (epoprostenol) for Injection	◯ Current	◯ Discontinued
Winrevair™ (sotatercept-csrk) for Injection	◯ Current	◯ Discontinued
Other: _____	◯ Current	◯ Discontinued

Patient Name (first, MI, last) | Date of Birth

Voucher Prescription ► See full program requirements and conditions at www.Yutrepia.com/Voucher

The YUTREPIA Voucher Program provides a one-time, 28-day supply, of free product to eligible patients to help them determine whether YUTREPIA is the right choice for them. Using the Voucher Rx does not require ongoing use of YUTREPIA with a Standard Rx.

VOUCHER PRESCRIPTION INFORMATION

YUTREPIA™ (treprostinil) inhalation powder

Starting Dose: _____mcg **Target Dose:** _____mcg

Dispense: 28-day supply, 0 refills

Frequency: Two (2) breaths per capsule, four (4) times daily **OR**
☐ Two (2) breaths per capsule, ____ times daily

Titration: (as tolerated, to target dose) Increase by 26.5 mcg every week, or as tolerated, **OR**
☐ Increase by _____ mcg, every _____ ☐ week(s) / ☐ days

NDC(s) Prescribed

SP will dispense the prescribed dose per needed NDC combinations.

Included NDCs in this prescription:

26.5 mcg	(72964-011-01)
53 mcg	(72964-012-01)
79.5 mcg	(72964-013-01)
106 mcg	(72964-014-01)

NURSING ORDERS

SP home health nurse visit(s) to teach and assess the self-administration of YUTREPIA, including dosing, titration, and side effect management.

☐ Decline Nursing Services

PRESCRIBER ATTESTATION

The undersigned, as treating physician, attests that:

(i) I understand and agree that the sole purpose of this prescription (and the subsequent dispense of the medication) under Liquidia's Voucher Program is solely to clinically evaluate the medication's safety and tolerability in order to determine if it is the right treatment choice for the patient.

(ii) I understand that patients are limited to one (1) free 28-day supply of YUTREPIA per lifetime under Liquidia's Voucher Program. Accordingly, I understand that should I and the patient determine that YUTREPIA is a good choice for the patient, I will need to write a new prescription of YUTREPIA for the patient in order to continue treatment.

(iii) I shall not seek reimbursement for YUTREPIA or any Liquidia medication dispensed to the patient through Liquidia's Voucher Program from any government program or third-party insurer.

(iv) I understand that any medication to be provided to this patient by Liquidia can only be provided directly to the patient or its authorized caregiver, is provided at no cost and may not be resold or billed to third-party payers, returned for credit or otherwise be placed in the stream of commerce.

(v) All patient information supplied to Liquidia or its agents, contractors or subcontractors in connection with this enrollment form is accurate and has been obtained pursuant to an appropriate and valid patient authorization allowing for the release, transfer, and use of such information by Liquidia or its agents, contractors and sub-contractors in accordance with State and Federal law.

(vi) I understand that Liquidia reserves the right to modify or terminate this program at any time as it deems fit, that Liquidia is under no obligation to continue the program and that any decision by Liquidia to modify or terminate this program will not give rise to any liability or obligation for Liquidia.

STATEMENT OF MEDICAL NECESSITY

I certify that the therapy ordered above is medically necessary and that I am personally supervising the care of this patient.

Prescriber Full Name (print)

SIGN HERE

Dispense As Written (DAW) / Brand Medically Necessary / No Substitution / May Not Substitute / Do Not Substitute

Prescriber Signature*

Substitution Permitted / May Substitute / Product Selection Permitted

Prescriber Signature*

Date

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution": _____

ATTN: New York and Iowa providers, please submit electronic prescription.

*Prescriber attests that this is his/her legal signature.

NO STAMPS. PRESCRIPTIONS MUST BE FAXED.

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 is not a guarantee of coverage or reimbursement.

Patient Name (first, MI, last)

Date of Birth

Voucher Prescription ►
In-hospital URGENT start request

Please complete the following information.

HOSPITAL AND CONTACT INFORMATION

Hospital Name

Patient Room No.

Caregiver Name

Hospital Main Phone

Patient Hospital Room Phone

Caregiver Phone

SPECIALTY PHARMACY / DELIVERY INSTRUCTIONS

Select a Specialty Pharmacy (SP):

◯ **Accredo Health Group**

Choose delivery method:

- ☐ Courier – delivered to the patient in the hospital (available in certain areas)
- ☐ Brown Bagging – delivered to the patient's home or alternate address for caregiver to bring to the hospital
- ☐ White Bagging – delivered to the prescriber's office for prescriber or staff member to bring to the hospital

◯ **CVS Specialty**

Choose delivery method:

- ☐ CVS Pharmacy – delivered to a local CVS Retail Pharmacy for caregiver to pick up and bring to the hospital
- ☐ CVS Nurse – SP nurse brings to the hospital during a scheduled nursing visit
- ☐ Brown Bagging – delivered to the patient's home or alternate address for caregiver to bring to the hospital
- ☐ White Bagging – delivered to the prescriber's office for prescriber or staff member to bring to the hospital

Please ensure that your patient or caregiver is available to answer the phone and respond to questions from the Specialty Pharmacy for the following interactions:

- To complete the voucher enrollment questions
- To speak with a pharmacist for the counseling call
- To speak with the Specialty Pharmacy nurse (if ordered) to schedule a visit

Yutrepia™ (treprostinil) inhalation powder

FAX

Using this cover sheet, fax all pages of the enrollment form, along with the requested clinical documentation, to the Specialty Pharmacy of your choice below.

Date

TO

☐ **Accredo Health Group, Inc.**

FAX 1-800-711-3526

Phone: 1-866-344-4874

☐ **CVS Specialty**

FAX 1-877-943-1000

Phone: 1-877-242-2738

FROM

(Name of agent of prescriber transmitting this fax/prescription)

Phone

Facility Name

Fax

RE

Patient Name

Date of Birth

DOCUMENTATION CHECKLIST

Indicate all current, signed and dated documents enclosed with this fax.

- ☐ Completed YUTREPIA Enrollment Form, including:
  - – Patient and Prescriber Information
  - – Insurance Information*
  - – Standard and/or Voucher Prescription Information
  - – Medical Information/Patient Evaluation
- ☐ Copy of front and back of patient's insurance card(s)*
- ☐ Right heart catheterization
- ☐ High-resolution CT scan ***(not required for PAH patients)***
- ☐ Echocardiogram ***(not required for PH-ILD patients)***
- ☐ 6-minute walk test results ***(not required for PH-ILD patients)***
- ☐ History and physical, including onset of symptoms, clinical signs and symptoms and course of illness
- ☐ Need for specific drug therapy

*Only required if requesting a Standard Rx

Comments:

No of Pages (including this cover sheet)