Yutrepia™ (treprostinil) inhalation powder

VOUCHER PROGRAM

The YUTREPIA Voucher Program provides a one-time, 28-day supply, of free product to eligible patients to help them determine whether YUTREPIA™ (treprostinil) inhalation powder is the right choice for them.

IS MY PATIENT ELIGIBLE?

Patients may be eligible for the YUTREPIA Voucher Program if they have been prescribed YUTREPIA for an FDA-approved indication, and are 18 years of age or older, or are enrolled by their legal guardian(s), if under 18 years of age.

CONDITIONS

- As a condition to participation, neither patients nor their medical providers may seek reimbursement from any health insurer or other third party payer (including without limitation federal, state, or private payers or any Flexible Spending Account (FSA), Health Savings Account (HSA), or Health Reimbursement Account (HRA)) for product provided under the YUTREPIA Voucher Program.
- Patients enrolled in a Medicare Part D plan may be eligible for this free 28-day trial offer, but they may not submit a claim for the free product provided under this program to Medicare Part D or any other insurer or count the assistance provided under the voucher program toward their true out-of-pocket (TrOOP) costs.
- Patients are limited to one (1) free 28-day supply of YUTREPIA per lifetime under the voucher program.
- Program subject to change or discontinuation without notice at any time for any reason, including in specific states.
- This program offer may not be combined with any other coupon, discount, prescription savings card, free trial, or other offer.
- This program is not insurance, and cannot be transferred or substituted.

QUESTIONS

919.415.4957 (Monday-Friday, 9 AM-6 PM ET)

YUTREPIA.COM

Please see the full Prescribing Information and Medication Guide.

Enrollment in this program is not conditioned in any way on purchase of any goods or services. Patients may unsubscribe from this program at any time by contacting the Liquidia Access Program at 2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560.

VOUCHER PROGRAM ENROLLMENT

Yutrepia™ (treprostinil) inhalation powder

Complete all sections on this voucher program enrollment form. Let your patient know that the specialty pharmacy (SP) will be calling to process their prescription and that it is important to answer or return any messages.

Sign the nursing orders on page 1 for patient nurse visits.

Sign the statement of medical necessity on page 2 for the prescription.

Sign the physician attestation on page 3.

Fax both pages of the completed voucher program enrollment form (using fax cover sheet provided) to your selected SP.

PATIENT INFORMATION

Patient Name (first, MI, last)

Date of Birth (mm/dd/yyyy)

Gender: ◯ Male ◯ Female

Address

Email

City | State | Zip

Phone ☐ Home ☐ Cell ☐ Work

Alternate Phone ☐ Home ☐ Cell ☐ Work

SHIPPING ADDRESS (if different from above):

Address

City | State | Zip

Preferred contact: ◯ Phone ◯ Email

Best time to call: ◯ Morning ◯ Afternoon ◯ Night

CAREGIVER

Caregiver Name

Caregiver Email

Caregiver Phone ☐ Home ☐ Cell ☐ Work

Alternate Phone ☐ Home ☐ Cell ☐ Work

Preferred contact: ◯ Phone ◯ Email

Best time to call: ◯ Morning ◯ Afternoon ◯ Night

NURSING ORDERS

NURSE VISITS (select **one** option)

◯ SP home healthcare RN visit(s) to provide assessment and education on self-administration of YUTREPIA™ to include dose, titration, and side effect management **OR**

◯ Prescriber-directed SP home healthcare RN visit(s) as detailed below:

Location:
- ◯ Home
- ◯ Outpatient clinic
- ◯ Hospital
- ◯ Virtual

PRESCRIBER SIGNATURE

SIGN HERE

Prescriber Signature | Prescriber Full Name (print) | Date

VOUCHER PROGRAM ENROLLMENT

Yutrepia™ (treprostinil) inhalation powder

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

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

PRESCRIPTION INFORMATION

YUTREPIA™ (treprostinil) inhalation powder

Starting Dose: _____ mcg

Target Dose: 159 mcg **OR** ◯ _____ mcg

Check off all NDC(s) to ensure SP is able to dispense labeled combinations needed to achieve prescribed dose.

WHO Group:
- ◯ **1** (PAH patients)
- ◯ **3** (PH-ILD patients)

NDC(s) Prescribed:
- ◯ 26.5 mcg(72964-011-01)
- ◯ 53 mcg(72964-012-01)
- ◯ 79.5 mcg(72964-013-01)
- ◯ 106 mcg(72964-014-01)

Quantity: 28-day supply **Refills:** No refills

Inhale: Two (2) breaths per capsule, four (4) times daily. Increase by 26.5 mcg, four (4) times daily, every week, as tolerated, to target maintenance dose.

OR

◯ Two (2) breaths per capsule, ____ times daily. Increase by _____ mcg, ____ times daily, every ____ ☐ week(s) / ☐ days, as tolerated, to target maintenance dose.

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 the labeled combinations needed to achieve the prescribed dose

STATEMENT OF MEDICAL NECESSITY

I certify that the therapy ordered above is medically necessary for an FDA-approved indication and that I am personally supervising the care of this patient.

SIGN HERE

Prescriber Signature* | Prescriber Full Name (print) | Date

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

NO STAMPS. PRESCRIPTIONS MUST BE FAXED.

VOUCHER PROGRAM

Yutrepia™ (treprostinil) inhalation powder

Patient Name (first, MI, last)

Date of Birth

PHYSICIAN 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.

PRESCRIBER SIGNATURE

SIGN HERE

Prescriber Signature

Prescriber Full Name (print)

Date

FAX

Yutrepia™ (treprostinil) inhalation powder

Using this cover sheet, fax all pages of the voucher program enrollment form 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

Comments:

No of Pages (including this cover sheet)