

Referral Form for REMODULIN



Remodulin is available only through select Specialty Pharmacy Services (SPS) providers.

Follow these 5 steps to complete each section of the following referral form.

GET STARTED CHECKLIST

- 1** Fill out the Patient and Insurance Information. Let your patient know that an SPS provider will be calling, and it is important to answer or return the call.
- 2** Complete and sign the Prescriber Information, Prescription, Medical Information and Statement of Medical Necessity.
- 3** Complete and sign the Treatment History, Transition Statement, and Calcium Channel Blocker Statement.
- 4** Complete the Optional Side Effect Management page.
- 5** Attach the clinical documents outlined on the **fax cover sheet**, including right heart catheterization test results, history and physical, and echocardiogram results. Use the **fax cover sheet** to fax the referral form and signed supporting documents to your preferred SPS provider. (Note: Insurance plans vary and may impact the approval process.)

STEP 1 PATIENT INFORMATION

Name - First	Middle	Last
Date of Birth	Gender	Last 4 Digits of SSN
Home Address		
City	State	Zip
Shipping Address (if different from home address)		
City	State	Zip
Telephone: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	Alternate Telephone: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	Best Time(s) to Call: <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening
E-mail Address		
Caregiver/Family Member	Caregiver E-mail Address	
Caregiver Telephone: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	Caregiver Alternate Telephone: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	Okay to Leave a Message? <input type="checkbox"/> Yes <input type="checkbox"/> No

STEP 1 INSURANCE INFORMATION

Primary Prescription Insurance		
Subscriber ID #	Group #	Telephone
Primary Medical Insurance		
		Policy Holder/Relationship
Subscriber ID #	Group #	Telephone
Secondary Medical Insurance		
		Policy Holder/Relationship
Subscriber ID #	Group #	Telephone

Please include copies of the front and back of the patient's medical and prescription insurance card(s).

Patient Name: _____ Date of Birth: _____

STEP 2 PRESCRIBER INFORMATION

Prescriber Name - First _____ Last _____
 NPI # _____ State License # _____
 Office/Clinic/Institution Name _____
 Address _____
 City _____ State _____ Zip _____
 Telephone _____ Fax _____
 E-mail Address _____ Office Contact Name _____
 Office Contact Phone _____ Office Contact E-mail _____
 Preferred Method of Communication Phone Email Mail Fax

STEP 2 REMODULIN PRESCRIPTION INFORMATION

Vial concentration:
 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)

Quantity: Dispense 1 month of drug and supplies X _____ refills

Patient dosing weight: _____ kg lb

Infusion Type:
 Subcutaneous continuous infusion Intravenous continuous infusion

Pumps:
 CADD-MS® 3 Pumps (2) CADD-Legacy® Pumps (2)
 Remunity® Pump for Remodulin (Remunity Pumps (2), Remotes, Batteries + Chargers):
 Patient Fill Specialty Pharmacy Fill

Please see the bottom of the page for Specialty Pharmacy fill information.

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.

Prescriber may specify any alternative or additional dosing and titration instructions here. For Remunity Pump System, titration is done at cassette change.

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.

Central Venous Catheter Care:
 Dressing change every _____ days Per IV standard of care

Check One (0.9% Sodium Chloride will be used if no box is checked):
 Remodulin Sterile Diluent for Injection 0.9% Sodium Chloride for Injection
 pH 12 Sterile Diluent for Injection Sterile Water for Injection
 Epoprostenol Sterile Diluent for Injection

Nursing Orders: RN visit to provide assessment and education on administration, dosing, and titration.

Location: Home Outpatient Clinic Hospital

Prescriber-directed Specialty Pharmacy home healthcare RN visit(s) as detailed below:

For Remunity Pharmacy-Filled Cassettes:

Remunity Pump for Remodulin
 Pharmacy-Filled Starter Kit (Remunity Pumps (2), Remotes, Batteries + Chargers)
 Remunity Disposable Cassettes

Dispense prefilled Remunity cassettes containing prescribed concentration (filled by Specialty Pharmacy per USP 797 guidelines or equivalent), ancillary supplies, medical equipment necessary to administer medication. For patients on Remunity, cassettes are changed up to 48 hours or 72 hours. Any unused medication must be discarded. For initiation of Remodulin in the hospital and Remunity transition post discharge, collaboration from both SP and ordering prescriber are necessary.

Dispense 1 week of Remodulin (treprostinil) for emergency supply, and quantity sufficient of prescribed syringes, needles, and any other necessary supplies to fill cassette and administer for emergency supply.

Dispense teaching kits (syringes, needles, and any other necessary supplies to mix and assess patient's mixing skill). Quantity: Up to 4 kits per quarter and refill x1 year.

Dispense 1 month of needles, syringes, ancillary supplies, and medical equipment necessary to administer medication.

STEP 2 MEDICAL INFORMATION / PATIENT EVALUATION / SUPPORTING DOCUMENTATION

Patient UT PAH Product Therapy Status for the requested drug:

Naïve/New Restart Transition

Current Specialty Pharmacy:

Accredo Health Group, Inc. CVS Specialty

Patient Status:

Outpatient Inpatient

NYHA Functional Class:

I II III IV

Weight: _____ kg lb

Height: _____ ft _____ in

Diabetic: Yes No

WHO Group: _____

Allergies: Drug Allergies Non-Drug Allergies No Known Allergies

Diagnosis: The following ICD-10 codes do not suggest approval, coverage, or reimbursement for specific uses or indications.

I27.0 Primary pulmonary hypertension:
 Idiopathic PAH Heritable PAH

I27.21 Secondary pulmonary arterial hypertension:
 Connective tissue disease Portal Hypertension
 Congenital Heart Disease HIV
 Drugs/Toxins induced Other _____

Other ICD-10: _____

Current Signed and Dated Documents Required for treprostinil therapy initiation:

Right Heart Catheterization
 Echocardiogram
 History and Physical Including: Onset of Symptoms, PAH Clinical Signs and Symptoms, Need for Specific Drug Therapy, Course of Illness
 Treatment History (included on the next page)
 Transition Statement (if applicable)
 Calcium Channel Blocker Statement (included on the next page)

The Prescriber is to comply with their state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance of state-specific requirements could result in outreach to the Prescriber.

STEP 2 PRESCRIBER SIGNATURE: PRESCRIPTION AND STATEMENT OF MEDICAL NECESSITY

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

PHYSICIAN'S SIGNATURE REQUIRED TO VALIDATE PRESCRIPTIONS.

Physician's Signature: _____ Dispense as Written _____ Substitution Allowed _____ Date: _____

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

(Physician attests this is his/her legal signature. NO STAMPS.) PRESCRIPTIONS MUST BE FAXED.

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Fax the completed referral form and documentation to the specialty pharmacy of your choice below.

STEP 5 FAX COVER SHEET

Date: _____

To: (check one) [] Accredio Health Group, Inc. [] CVS Specialty
Fax: 1-800-711-3526 Fax: 1-877-943-1000
Phone: 1-866-344-4874 Phone: 1-877-242-2738

From: (Name of agent of prescriber who transmitted the facsimile/Prescription)

Facility Name: _____

Fax: _____

Included in this fax:

- [] Completed Remodulin Therapy Referral Form including
• Step 1 - Patient Information/Insurance Information (Including front and back copies of insurance card)
• Step 2 - Prescriber/Prescription Information/Medical Information/Patient Evaluation
• Step 3 - Treatment History/Transition Statement and Calcium Channel Blocker Statement
• Step 4 - Optional Side Effect Management
[] Included signed and dated documents
• Right Heart Catheterization Results
• History and Physical (including Onset of Symptoms, PAH Clinical Signs and Symptoms, Course of Illness)
• Need for Specific Drug Therapy and 6-minute walk test results
• Echocardiogram Results

Number of Pages: _____

Additional Comments:

Multiple horizontal lines for additional comments.

US-REM-0747

