Orenitram® (treprostinil) Extended-Release Tablets Referral Form

Please complete, sign, and fax Steps 1 through 7 to ASSIST using the included Fax Cover Sheet. * REQUIRED FIELD

orenitram treprostinil EXTENDED-RELEASE TABLETS

GET STARTED CHECKLIST

Follow these 7 steps to complete each section of the following referral form.

☐ 1 **Obtain all the necessary documentation from your patient to fill out the Patient Information. Include copies of the front and back of all patient's medical and prescription insurance cards and/or a copy of the patient's demographic/face sheet with medical and prescription insurance information to ASSIST.**

Let your patient know that an Access Solutions and Support Team (ASSIST) representative will be calling to verify insurance coverage or to obtain additional information. It is very important he or she answers or returns the call in a timely manner or the approval process could be delayed.

Complete the:

- ☐ 2 **Prescriber Information**
- ☐ 3 **Medical Information / Patient Evaluation / Supporting Documentation**
- ☐ 4 **Prescription Information**

☐ 5 **Sign and complete the Statement of Medical Necessity**

☐ 6 **Patient to sign and complete the Patient Support Program Patient Authorization**

☐ 7 **Use the included Fax Cover Sheet to fax the completed referral form and any relevant clinical documents to ASSIST.**

Include any comments in the section provided on the Fax Cover Sheet.

NOTE: Prior authorization may be required for each prescribed dosing strength of Orenitram. Please plan ahead for titration when completing and submitting this referral form for prior authorization to help avoid delays in treatment initiation.

SUPPORT FOR YOU AND YOUR PATIENTS

assist Access Solutions and Support Team UNITED THERAPEUTICS

United Therapeutics Support

ASSIST is a centralized referral service that helps simplify the referral process by providing support until your patients receive their first shipment of medication.

Once you prescribe Orenitram and submit your initial referral form, ASSIST will help

- Discuss financial assistance options with patients
- Obtain any additional information needed from your patients
- Arrange for a specialty pharmacy to provide home medication history

If you or your patients have any questions about completing the referral forms, financial assistance options, or program eligibility, please contact ASSIST at 1-877-864-8437.

*Patients must meet certain eligibility criteria to qualify for financial assistance.

Specialty Pharmacy Services (SPS)

SPS works with you to support your patients.

SPS providers are available to answer questions from your patients or your practice regarding treatment with Orenitram and to work with you to get your patients started on therapy in a timely manner.

In-home nurse visits and follow-up communication for Orenitram patients include

- In-home nurse visits
- Scheduled follow-up calls from both nurses and pharmacists
- 24-hour SPS telephone support
- Additional visits available upon request

1 PATIENT INFORMATION

* Name: First _____ * Middle _____ * Last _____

* Date of Birth _____ Gender _____ * Last 4 Digits of SSN _____ E-mail Address _____

* Home Address _____ * 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 ☐ Anytime

Caregiver/Family Member _____ Caregiver E-mail Address _____

* Caregiver Telephone: ☐ Home ☐ Cell ☐ Work Alternate Telephone: ☐ Home ☐ Cell ☐ Work OK to leave a message? ☐ Yes ☐ No

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Patient Name: _____ Date of Birth: _____

2 PRESCRIBER INFORMATION

* Name: First | * Last | * NPI #

* Office/Clinic/Institution Name | Group NPI # (if applicable) | * State License #

* Address | * City | * State | * Zip

* Office Contact Name | * Telephone | * Fax

Office Contact E-mail Address | Preferred Method of Communication ☐ Phone ☐ E-mail ☐ Mail ☐ Fax

3 MEDICAL EVALUATION / PATIENT EVALUATION / SUPPORTING DOCUMENTATION

* **Patient UT PAH Product Therapy Status for the Requested Drug:**
☐ Naive/New ☐ Restart ☐ Transition

* **Current Specialty Pharmacy:**
☐ Accredo Health Group Inc. ☐ CVS Specialty

* **Patient Status:**
☐ Outpatient ☐ Inpatient

* **Diabetic:**
☐ Yes ☐ No

* **WHO Group:** _____

* **NYHA Functional Class:**
☐ I ☐ II ☐ III ☐ IV

* **Weight:**_____ ☐ kg ☐ lb
* **Height:** _____ ft _____ in

* **Allergies:**
☐ Yes ☐ No ☐ No Known Drug Allergies If yes _____

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

* 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 ☐ Portal Hypertension
☐ Drugs/Toxins Induced ☐ HIV ☐ Other _____

Other ICD-10 _____

* List PAH-specific medications patient is taking or has taken _____

4 PRESCRIPTION INFORMATION (the prescription is only valid if received by fax)

Initial and Continued Titration

☐ **Titration Kit (3-month supply); 0 Refills**
Month 1 (NDC 66302-361-28), 126 tablets of 0.125 mg and 42 tablets of 0.25 mg
Month 2 (NDC 66302-362-56), 126 tablets of 0.125 mg and 210 tablets of 0.25 mg
Month 3 (NDC 66302-363-84), 126 tablets of 0.125 mg, 42 tablets of 0.25 mg and 84 tablets of 1 mg

Directions: Initiate at 0.125mg TID. Titrate by 0.125mg TID every 7 days until a dose of 1.5mg TID is achieved by end of titration pack month 3.

☐ **Prescription Beyond Month 3 (please select strengths to the right)**

Titrate by _____mg TID every _____ days until goal dose of _____mg TID is achieved

OR Alternate Dosing Instructions (please select strengths to the right)

☐ Initiate at _____ mg ☐ **TID OR** ☐ **BID (choose one)**. Titrate by _____ mg every ____ days until goal dose of _____ mg is achieved.

* **STRENGTHS** (Prior authorizations may be required for each strength. Select all appropriate strengths needed to reach target dose.):

☐ 0.125 mg (NDC 66302-300-01)
☐ 0.25 mg (NDC 66302-302-01)
☐ 1 mg (NDC 66302-310-01)
☐ 2.5 mg (NDC 66302-325-01)
☐ 5 mg (NDC 66302-350-01)

PRESCRIBER TO SPECIFY ANY ALTERNATIVE OR ADDITIONAL DOSING AND TITRATION INSTRUCTIONS HERE: _____

* **DISPENSE:** Quantity sufficient for up to maximum allowable dose for one (1) month's supply. **Refills** ☐ 12 months **OR Refills** _____time(s)

DIRECTIONS: Take tablets by mouth with food

For Orenitram dosing and titration information, please see the Dosage and Administration section of the Prescribing Information.

Specialty Pharmacy to contact Prescriber for adjustments to written orders specified above. The Prescriber is to comply with his/her state-specific prescription requirements, such as e-prescribing, state-specific prescription form, fax language, etc. Noncompliance with state-specific requirements could result in outreach to the Prescriber.

NURSE VISITS:

CHOOSE ONE

☐ **OPTION 1: Specialty Pharmacy home health care RN visit(s)** to provide education on self-administration of Orenitram to include dose, titration, and side effect management

☐ **OPTION 2: Prescriber-directed Specialty Pharmacy home health care RN visit(s) as detailed:** _____

OPTIONAL SIDE EFFECT MANAGEMENT

Provide any additional instructions for SP on preferred communication or managing other side effects (e.g., diarrhea, headache, nausea, etc.). Note: SPS offers additional in-home nurse visits on request: _____

5 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 ASSIST 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. PHYSICIAN SIGNATURE REQUIRED TO VALIDATE PRESCRIPTIONS.

SIGN HERE

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

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

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 ASSIST, is not a guarantee of coverage or reimbursement.

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Patient Name: _____ Date of Birth: _____

6 PATIENT AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize my health care providers, including my pharmacies and health plan(s) ("Health Care Providers") to disclose my personal information, including information about my insurance, prescriptions, medical condition, and health ("Information") to United Therapeutics and its contractors and business partners (including the Access Solutions and Support Team [ASSIST]) (collectively "United Therapeutics") for the following purposes:

to (1) verify, investigate, and assist with the coordination of my insurance coverage for United Therapeutics products; (2) facilitate my access to prescribed United Therapeutics products; (3) contact me to discuss available patient support programs; (4) determine my initial and continuing eligibility for assistance programs; (5) provide educational information and promotional materials related to United Therapeutics products or my condition or treatment; (6) allow internal review by United Therapeutics of its programs for continuous improvement; and (7) use my deidentified information for ongoing analysis and quality improvement for United Therapeutics medicines.

Certain Health Care Providers may receive payment from United Therapeutics in exchange for disclosing my Information as described above and/or for using my Information to contact me about United Therapeutics products and other support programs.

I understand that federal privacy laws may not protect my Information once it is disclosed; however, United Therapeutics agrees to protect my Information by using and disclosing it only for the purposes specified. **I understand that I may refuse to sign the authorization and that this refusal will not affect my treatment, insurance coverage, or eligibility for benefits. However, if I do not sign, I may not be eligible to receive education and patient support services provided by United Therapeutics.**

This authorization will expire in ten (10) years after the date it is signed unless a shorter period is mandated by state law or I revoke or cancel my authorization before then. I understand that I may cancel this authorization at any time by fax at 1-800-380-5294 or by writing to United Therapeutics Corporation ASSIST, 1130 S. Harbor City Blvd., Suite 103, Melbourne, Florida 32901, but the cancellation will not apply to information that Health Care Providers have previously disclosed in reliance on this authorization. I understand that I am entitled to receive a copy of this authorization once signed.

SIGN HERE

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

If the patient cannot sign, patient's representative must sign here. Patient Representative Signature _____ Date _____

Describe relationship to patient and authority to sign this form for patient:_____

ORENITRAM PATIENT SUPPORT PROGRAM

By checking the box below, the patient agrees to be enrolled in the Orenitram Patient Support Program, which includes receiving information from United Therapeutics regarding programs and services related to my condition, including treatment information. Information sent by United Therapeutics does not take the place of talking to your health care provider about your treatment or condition. United Therapeutics, or third parties working on its behalf, will not sell your information or use it for any unrelated purposes. If, in the future, you no longer want to receive these materials or participate in these programs, please call 1-877-864-8437. Please visit Orenitram.com to review the United Therapeutics Privacy Notice.

CHECK HERE

☐ **By checking this box, I agree to be enrolled in the Orenitram Patient Support Program.**

ARCHWAYS LIVE VIRTUAL EDUCATOR PROGRAM

By checking the box below, the patient agrees to be contacted by phone by an Archways representative to provide live information about the Archways Virtual Educator Program, a convenient, no-cost, educational patient support program offered by United Therapeutics. You may enroll in Archways immediately after you have been prescribed Orenitram by your Healthcare Provider. United Therapeutics and the Archways program do not provide medical advice. You are advised to consult with your Healthcare Provider with any specific questions or concerns about your treatment. Please visit UTArchways.com to learn more about the Archways Virtual Educator Program.

CHECK HERE

☐ **By checking this box, I agree to be contacted by phone with more information about the Archways Virtual Educator Program.**

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7 FAX COVER SHEET

Date:

To:

assist Access Solutions and Support Team UNITED THERAPEUTICS

Fax Number 1-800-380-5294
Phone Number 1-877-864-8437

From:

Facility Name:

Fax:

Included in this fax:

- ☐ **Completed UT PAH Therapy Referral Form including**
  - ☐ **Step 1 - Patient Information**
  - ☐ **Step 2 - Prescriber Information**
  - ☐ **Step 3 - Medical Information**
  - ☐ **Step 4 - Prescription Information**
  - ☐ **Step 5 - Prescriber Signature**
  - ☐ **Step 6 - Patient Support Program Patient Authorization**
  - ☐ **Copy of Insurance Card(s)**

Number of Pages:

Comments:

Prescriber's Preferred Specialty Pharmacy - To be used if patient's payer does not mandate a particular Specialty Pharmacy be used:

☐ **Accredo Health Group, Inc.** ☐ **CVS Specialty**

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