SPmix Enrollment Form for REMODULIN® (treprostinil) Injection
United Therapeutics Corporation Therapy Enrollment Form

Please complete, sign, and fax Steps 1 and 2, along with requested clinical documentation, to your preferred Specialty Pharmacy using the enclosed Fax Cover Sheet.

STEP 1 - PATIENT INFORMATION

A PATIENT INFORMATION

Name: First	Middle	Last
Date of Birth	Gender	Last 4 digits of SSN
Home Address		
City	State	Zip
Shipping Address	(if not home address)	
City	State	Zip
Telephone	Alternate Telephone	Best Time to Call
E-mail Address	Cell Phone	Work Phone
Caregiver/Family Member	Telephone	Alternate Telephone

☐ **By checking this box I authorize SPS to leave a message with a caregiver/family member.**

B INSURANCE INFORMATION

Pharmacy Benefits Manager:

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 insurance card(s).

Please Note: Each practitioner is solely responsible for ensuring the accuracy of the information submitted. State- and Payer-specific requirements may vary.

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Patient Name: _____

Date of Birth: _____

STEP 2 - PRESCRIBER INFORMATION AND PRESCRIPTION INFORMATION

C PRESCRIBER INFORMATION

Prescriber Name: First	Last		
NPI #	State License #		
Facility Name		TIN #	
Address	City	State	Zip
Telephone		Fax	
E-mail Address	Preferred Method of Communication		

D MEDICAL INFORMATION / PATIENT EVALUATION

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

IDC-10 I27.21 Other chronic pulmonary heart diseases: pulmonary arterial hypertension, secondary
☐ Connective tissue disease ☐ Congenital Heart Disease ☐ Portal Hypertension
☐ Drugs/Toxins induced ☐ HIV ☐ Other _____

Other ICD-10
_____

Allergies ☐ Yes ☐ No If yes _____ Weight _____ kg/lb Height _____ Diabetic ☐ Yes ☐ No

E PRESCRIPTION INFORMATION

☐ **REMODULIN® (treprostinil) Injection**

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)
Refills 1 year or _____ **Patient dosing weight:** _____ ☐ kg ☐ lb

Diluent: Remodulin® Sterile Diluent for Injection

Infusion Type ☐ **Intravenous continuous infusion**

Dosing and Titration Instructions

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

Specify Current Dose: _____ Concentration: _____ Pump rate: _____

- Dispense 1 week of Remodulin (treprostinil) premixed cassettes containing prescribed concentration (compounded by specialty pharmacy per USP 797 guidelines), ancillary supplies, and medical equipment necessary to administer medication. Cassette to be changed 48 hours after infusion start or as directed.
- Dispense 1 week of Remodulin (treprostinil) for emergency supply, and quantity sufficient of prescribed diluent, syringes, needles, and any other necessary supplies to mix and administer for emergency supply.
- Dispense teaching kits (diluent, syringes, needles, and any other necessary supplies to mix and assess patient's mixing skills). Quantity: up to 4 kits per quarter and refill ×1 year.
- Dispense 1-month of needles, syringes, ancillary supplies, and medical equipment necessary to administer medication.

Central venous catheter care: ☐ Dressing change every _____ days ☐ Per IV standard of care

Pumps: ☐ 2 CADD-Legacy® Pumps

RN visits to provide assessment and education on administration, dosing, titration and transitioning to pre-mix cassettes with the use of teaching kits
☐ quarterly or ☐ every 6 months

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

F 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 who has been on Remodulin IV for the past 3 months and a steady dose for at least 1 month. I authorize United Therapeutics Corporation, its affiliates, agents, and contractors (collectively, United Therapeutics) 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.

Physician's signature _____ _____ Date _____
Dispense as Written **Substitution Allowed**

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

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STEP 3

FAX COVER SHEET

Date:

To: ☐ **Accredo**
Fax: 1-800-711-3526
Phone: 1-866-344-4874

☐ **CVS Caremark**
Fax: 1-877-943-1000
Phone: 1-877-242-2738

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

Facility Name:

Fax:

Included in this fax:

☐ **Completed SPmix Enrollment Form including:**
Step 1 - Patient Information
Step 2 - Prescriber/Prescription Information

☐ **Medication History**

Number of Pages:

Comments:

Please Note: Each practitioner is solely responsible for ensuring the accuracy of the information submitted. State- and Payer-specific requirements may vary.

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