United Therapeutics Orenitram® (treprostinil)
Patient Enrollment and Specialty Pharmacy Referral Form

orenitram treprostinil EXTENDED-RELEASE TABLETS

Orenitram is available only through select Specialty Pharmacy Services (SPS) providers. This Patient Enrollment and Specialty Pharmacy Referral Form collects the information necessary for the SPS providers to process prescriptions and provides patients with the opportunity to enroll in the patient support program known as United Therapeutics Cares™.

Follow these 8 steps to complete each section of the following referral form.

GET STARTED CHECKLIST

- ☐ 1 Review the service(s) for which your patient is applying to receive from United Therapeutics Cares.
- ☐ 2 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 United Therapeutics Cares. Let your patient know that a United Therapeutics Cares Patient Navigator will be calling, and it is important to answer or return the call.
- ☐ 3 Complete the Prescriber Information.
- ☐ 4 Complete the Medical Information.
- ☐ 5 Complete the Prescription, including the Optional Side Effect Management and signing the Statement of Medical Necessity.
- ☐ 6 Patient to review, fill out checkbox consents (as applicable) and sign Patient Consent statement.
- ☐ 7 Patient to review and sign Patient Authorization statement.
- ☐ 8 Attach the clinical documents outlined on the **Fax Cover Sheet**, including right heart catheterization test results, history and physical, and echocardiogram results. Use the included **Fax Cover Sheet** in this PDF to fax the referral form and signed supporting documents to United Therapeutics Cares. (Note: Insurance plans vary and may impact the approval process.)

1 UNITED THERAPEUTICS CARES

United Therapeutics Cares™

United Therapeutics Corporation ("United Therapeutics") offers United Therapeutics Cares to help patients start their prescribed United Therapeutics medications. By completing and submitting this Referral Form, the patient agrees to be screened for and receive, if applicable, the following services:

Scan to add United Therapeutics Cares to your phone contacts

Access and Affordability Support: United Therapeutics Cares provides support to educate patients and caregivers on their insurance coverage, answer access-related questions, and discuss financial assistance eligibility and enrollment options. United Therapeutics Cares investigates patients' insurance coverage (including prior authorization and appeals process requirements and guidelines), as well as patients' eligibility for affordability programs and other support options, such as the United Therapeutics Cares Patient Assistance Program and other United Therapeutics free drug programs and co-pay assistance.

Product Education: United Therapeutics Cares offers a dedicated point of contact for patients and provides disease and product education support to patients and their caregivers as they start and continue their medication journey.

Coordination: United Therapeutics Cares offers a dedicated point of contact who works with patients and their caregivers, specialty pharmacies and healthcare providers to help reduce non-clinical barriers to therapy, including conducting prescription triage, coordinating delivery, and checking in with patients on an ongoing basis post therapy initiation.

United Therapeutics Cares Patient Assistance Program: The United Therapeutics Cares Patient Assistance Program offers a free medication program for uninsured and underinsured patients who meet eligibility requirements (additional information can be found on our website at www.UnitedTherapeuticsCares.com).

Consent to enroll in the services does not guarantee that any service(s) will be provided. Patient and healthcare provider acknowledge that additional information may be needed to assess eligibility for and provide the services. Consent is not required to submit a prescription and have a specialty pharmacy process the prescription.

2 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

United Therapeutics Orenitram® (treprostinil) Patient Enrollment and Specialty Pharmacy Referral Form

Please complete, sign, and fax Steps 1 through 8 to United Therapeutics Cares using the included Fax Cover Sheet. * **REQUIRED** FIELD

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Patient Name: _____ Date of Birth: _____

3 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

4 MEDICAL INFORMATION / 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 _____

5 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: _____

_____

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 Cares 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 United Therapeutics Cares, is not a guarantee of coverage or reimbursement.

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Patient Name: _____ Date of Birth: _____

6 PATIENT CONSENT

Enrolling in United Therapeutics Cares. By submitting this form, I am enrolling in **United Therapeutics Cares**, and I authorize United Therapeutics Corporation, its affiliated companies, vendors, agents, and representatives (collectively, "United Therapeutics") to provide me services through United Therapeutics Cares. Such services, as described on Page 1, include: **(1)** Access and Affordability Support, through which United Therapeutics Cares will provide support to educate patients and caregivers on their insurance coverage, answer access-related questions, and discuss financial assistance eligibility and enrollment options; **(2)** Product Education, through which United Therapeutics Cares offers a dedicated point of contact, who provides disease and product education support to patients and their caregivers; **(3)** Coordination, through which United Therapeutics Cares offers a dedicated point of contact who works with patients and their caregivers, specialty pharmacies and healthcare providers to help reduce non-clinical barriers to therapy, including conducting prescription triage, coordinating delivery, and checking in with patients on an ongoing basis post therapy initiation; and **(4)** United Therapeutics Cares Patient Assistance Program, which offers a free medication program for uninsured and underinsured patients who meet eligibility requirements (the "Services").

Verification of Eligibility. To the extent I am enrolling in the United Therapeutics Cares Patient Assistance Program, I authorize United Therapeutics to verify my eligibility for the Patient Assistance Program, and I understand that such verification may include contacting me or my healthcare provider for additional information and/or reviewing additional insurance, medical information and/or financial information. I understand that eligibility for participation will be verified periodically.

CHECK HERE ☐ By checking this box, I am providing written instructions authorizing United Therapeutics Cares, United Therapeutics and their vendors, under the Fair Credit Reporting Act to obtain information about my credit profile or other information from credit reporting agencies or public or other sources. I authorize United Therapeutics Cares to obtain such information solely to determine eligibility for enrollment in the United Therapeutics Cares Patient Assistance Program. I understand that such reports may contain information about my income, credit standing, credit worthiness, credit capacity, character or personal characteristics. I understand that, upon request, United Therapeutics will tell me whether an individual consumer report was requested and the name and address of the agency that furnished it. Enrollment and continuation in the United Therapeutics Cares Patient Assistance Program are conditioned upon timely verification of income.

Conditions of Participation. If I receive free drugs under the United Therapeutics Cares Patient Assistance Program, I certify that I will not seek payment for the United Therapeutics product from any government-funded healthcare program (Medicare/Medicaid/Veterans Administration/Department of Defense), and that I will not submit any costs paid by United Therapeutics Cares as a claim for payment to a health plan, foundation, flexible spending account, or healthcare savings account. I agree to notify United Therapeutics Cares if my insurance or financial situation changes. I certify that any information, including financial and insurance information I provide, is complete and true. I understand that United Therapeutics Cares may be changed or discontinued without notice.

Use of Personal Information. I understand through my submission of this Patient Enrollment and Referral Form, I consent to the collection, use and disclosure of my personal health data, contact information and other identifying information by United Therapeutics for provision of the Services and for other business purposes, as described in the United Therapeutics Privacy Statement, available at: **www.unither.com/privacy**. Depending on where I live, I may have certain rights with respect to the privacy of my information, including the request to access or delete my personal information, as described in the United Therapeutics Privacy Statement. If you are a California resident, please see our CCPA Notice at Collection provided within the United Therapeutics Privacy Statement. I am aware that United Therapeutics may not be required to fulfill my requests in certain circumstances. I understand that to exercise these rights, I may contact United Therapeutics at 844-864-8437 or privacyoffice@unither.com.

Communications. By checking the box(es) below, I hereby provide my consent to receive certain communications from United Therapeutics and its agents (including service providers on its behalf) by mail, fax, email, telephone (including cell phone) and text message. I understand and acknowledge that my personal information, including health information, may be used or disclosed as part of the communications. Communications transmitted via unencrypted email or text message over an open network may be inherently unsecure, and there is no assurance of confidentiality for information communicated in this manner.

UNITED THERAPEUTICS CARES TEXT COMMUNICATIONS AUTHORIZATION

CHECK HERE ☐ Yes, I consent to receive automated text messages from "United Therapeutics Cares" at the mobile phone number I have provided. Message and data rates may apply. Message frequency varies. I understand I am not required to consent to receive text messages to participate in United Therapeutics Cares, to purchase any goods or services, or to receive any other communications I have selected. I can reply HELP for help. I can reply STOP to opt out at any time. I understand the processing of my information is subject to the United Therapeutics Privacy Statement, www.unither.com/privacy, and Text Message Terms and Conditions, www.unither.com/textterms.

MARKETING AUTHORIZATION

CHECK HERE ☐ Yes, I consent to receive communications by mail, email, and telephone (including cell phone), including through automated technologies, at the number and address I have provided from United Therapeutics regarding its products, programs, services, disease state materials, educational and adherence materials, promotions, research and surveys, and other research opportunities. I understand the processing of my information is subject to the United Therapeutics Privacy Statement, www.unither.com/privacy.

Additional Information. Additional information on United Therapeutics Cares can be found on our website at www.UnitedTherapeuticsCares.com. If you have questions, want to update your information, or terminate your enrollment, please call 844-864-8437 Monday–Friday, 8:30 am–7:00 pm ET or write to us at P.O. Box 12015 Research Triangle Park, NC 27709.

6 PATIENT CONSENT SIGNATURE

SIGN HERE

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

Patient or Representative Signature: _____

Representative relationship to patient if patient cannot sign: _____

Patient Name: _____ Date of Birth: _____

7 PATIENT AUTHORIZATION TO SHARE HEALTH INFORMATION

United Therapeutics Corporation ("United Therapeutics") offers United Therapeutics Cares, which provides patient support services including educational resources, case management support, and financial assistance for eligible patients. By signing below, I give my permission for my healthcare providers, health plans, pharmacies, and other healthcare service providers ("My Healthcare Providers") to share with United Therapeutics, its present and future affiliates, vendors, and other companies, entities, and individuals working with and on behalf of United Therapeutics, personal information relating to my medical condition, prescriptions, treatment and health insurance information ("My Information") so that United Therapeutics may: **1)** review my eligibility for benefits for treatment with a United Therapeutics product; **2)** obtain information on insurance coverage for my treatment; **3)** access my credit information and information from other sources to estimate my income, if needed, to assess eligibility for financial assistance programs; **4)** facilitate and manage United Therapeutics Cares; **5)** coordinate treatment logistics with My Healthcare Providers; **6)** de-identify My Information and combine it with other de-identified data for purposes of research, process and program improvement, and publication; and **7)** communicate with me by telephone (including cell phone), text message, email, mail or fax regarding United Therapeutics Cares, United Therapeutics medications, products or services for the purposes set forth below, if I provide my consent.

I understand that once My Information has been disclosed to United Therapeutics pursuant to this Authorization, it may no longer be protected by federal and state privacy laws from further disclosure. I also understand however that United Therapeutics intends to use and disclose My Information only for purposes stated in this Authorization or as required by law. I understand that my pharmacy and health insurers may receive remuneration (payment) from United Therapeutics in exchange for sharing My Information with United Therapeutics to facilitate the patient support programs and other purposes described in this Authorization. I understand that My Information is also subject to the United Therapeutics Privacy Statement available at **www.unither.com/privacy**. **I understand that I may refuse to sign this Authorization, and that refusing will not affect my treatment, insurance enrollment, or eligibility for insurance benefits, but it will make me ineligible to participate in United Therapeutics' support programs.** If I do sign, I may cancel this Authorization at any time by mailing a letter to: United Therapeutics Cares, P.O. Box 12015 Research Triangle Park, NC 27709 or by emailing opt-out@unitedtherapeuticscares.com. I understand that canceling this Authorization will not invalidate reliance on this Authorization to use or disclose My Information prior to United Therapeutics' receipt of my notice of cancellation. This Authorization expires ten (10) years from the date next to my signature, unless I revoke it sooner, or unless a shorter timeframe is required by applicable law. I understand I have a right to receive a copy of this Authorization after it is signed.

7 PATIENT AUTHORIZATION SIGNATURE

SIGN HERE

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

Patient or Representative Signature: _____

Representative relationship to patient if patient cannot sign: _____

8 FAX COVER SHEET

Date: _____

To: United Therapeutics Cares™

Fax Number 1-800-380-5294
Phone Number 1-844-864-8437

From: _____

Facility Name: _____

Fax: _____

Included in this fax:

☐ **Completed UT PAH Therapy Referral Form including:**

- Step 2 - Patient Information
- Step 3 - Prescriber Information
- Step 4 - Medical Information
- Step 5 - Prescription Information, Optional Side Effect Management, and Statement of Medical Necessity
- Step 6 - Patient Consent
- Step 7 - Patient Authorization To Share Health Information
- **Copy of Insurance Card(s)**

Number of Pages: _____

Additional 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**

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