

YUTREPIA™ (treprostinil) inhalation powder is available through select specialty pharmacy (SP) providers.

Complete all sections on this enrollment form. Let your patient know that the Specialty Pharmacy will be calling to process their prescription and that it is important to answer or return any messages.

Sign the Statement of Medical Necessity on page 2 for the Prescription.

Sign at the bottom of page 3 and pages 4-5 (for PAH patients) or page 6 (for PH-ILD patients).

Fax the enrollment form and signed supporting documents (using fax cover sheet provided on page 7) to your selected SP.

PATIENT INFORMATION

Patient Name (first, MI, last)

Date of Birth (mm/dd/yyyy)

Gender: ☐ Male ☐ Female

Address

Email

Home
Cell
Work

Home
Cell
Work

City

State

Zip

Phone

Alternate Phone

SHIPPING ADDRESS (if different from above):

Preferred contact: ☐ Phone ☐ Email

Best time to call: ☐ Morning ☐ Afternoon ☐ Night

Address

City

State

Zip

CAREGIVER

Caregiver Name

Caregiver Phone

Home
Cell
Work

Alternate Phone

Home
Cell
Work

Preferred contact: ☐ Phone ☐ Email

Best time to call: ☐ Morning ☐ Afternoon ☐ Night

Caregiver Email

INSURANCE INFORMATION

Pharmacy Benefits Manager

Please include copies of the front and back of all patient's medical and prescription insurance cards.

PRIMARY Medical Insurance Carrier

SECONDARY Medical Insurance Carrier

Policyholder Name

Policyholder Name

Policy ID Number

Group Number (if applicable)

Policy ID Number

Group Number (if applicable)

Medical Insurance Phone

Relationship to Policyholder

Medical Insurance Phone

Relationship to Policyholder

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.

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 ☒ OR ☐ _____ day supply

Refills: 12 refills ☒ OR ☐ _____ 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

PRESCRIBER SIGNATURE IS REQUIRED TO VALIDATE PRESCRIPTIONS.

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

Dispense As Written (DAW) / Brand Medically Necessary / No Substitution / May Not Substitute / Do Not Substitute

Prescriber Full Name (print)

Substitution Permitted / May Substitute / Product Selection Permitted

SIGN
HERE

Prescriber Signature*

Prescriber Signature*

Date

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution": _____

ATTN: New York and Iowa providers, please submit electronic prescription.

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

NO STAMPS. PRESCRIPTIONS MUST BE FAXED.

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 is not a guarantee of coverage or reimbursement.

YUTREPIA™ is a trademark of Liquidia Technologies, Inc. Tyvaso® is a registered trademark of United Therapeutics Corporation. The use of Tyvaso® in this form is for identification purposes only and does not imply endorsement by United Therapeutics Corporation of any Liquidia Product.

Patient Name (first, MI, last)

Date of Birth

Prescriber Name (first, MI, last)

NPI #

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

***THE INFORMATION PROVIDED BELOW IS NOT A PRESCRIPTION.
IF ADDITIONAL PRESCRIPTIONS ARE INTENDED, PROVIDE TO THE PATIENT SEPARATELY.**

SIDE EFFECT MANAGEMENT (OPTIONAL)

Headache:

- ☐ Acetaminophen _____ mg Frequency: _____
- ☐ Opioids (*separate Rx required*)
- ☐ Tramadol (*separate Rx required*)
- ☐ NSAIDs (*separate Rx may be required*)
- ☐ Other: _____

Nausea/Vomiting:

- ☐ Ondansetron (*separate Rx required*)
- ☐ Metoclopramide (*separate Rx required*)
- ☐ PPIs (*separate Rx may be required*)
- ☐ Prochlorperazine (*separate Rx required*)
- ☐ Promethazine (*separate Rx required*)
- ☐ Remind patient to hold the device level and swish and spit after each treatment session
- ☐ Other: _____

Throat Irritation:

- ☐ Lozenges (*not to be used during treatment session*)
- ☐ Oral phenol-based analgesic sprays
- ☐ Review medication administration technique
- ☐ Other: _____

Cough:

- ☐ Albuterol (*separate Rx required*)
- ☐ Benzonatate (*separate Rx required*)
- ☐ Cough Suppressant (*separate Rx may be required*)
- ☐ Oral phenol-based analgesic sprays
- ☐ Lozenges (*not to be used during treatment session*)
- ☐ Inhaled anticholinergics (*separate Rx required*)
- ☐ Inhaled steroids (*separate Rx required*)
- ☐ Other: _____

Additional Instructions:

PRESCRIBER SIGNATURE

**SIGN
HERE**

Prescriber Signature

Prescriber Full Name (print)

Date

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Patient Name (first, MI, last)

Date of Birth

Prescriber Name (first, MI, last)

NPI #

PATIENT EVALUATION

Patient Status:

- ☐ Outpatient
☐ Inpatient

YUTREPIA™ Status:

- ☐ Naïve / New
☐ Restart
☐ Transition

WHO Group:

NYHA Functional Class:

- ☐ I ☐ II ☐ III ☐ IV

Diabetic?

- ☐ Yes
☐ No

Allergies:

- ☐ No known drug allergies (NKDA)
☐ Yes (specify): _____

Height:

Weight:

Date Taken:

cm kg
in lb

Current Medications (list all):

MEDICAL INFORMATION

REQUIRED: Please select one of the following ICD-10 codes, or Other ICD-10 code, as applicable. The following ICD-10 codes do not suggest approval, coverage, or reimbursement for specific uses or indications.

PAH

ICD-10 I27.0 Primary pulmonary hypertension

- ☐ Idiopathic PAH
☐ Heritable PAH

ICD-10 I27.2 Other secondary pulmonary hypertension

- ☐ Connective tissue disease ☐ Congenital heart disease
☐ Drugs/Toxins induced ☐ Portal hypertension
☐ HIV

☐ Other ICD-10

Code

Description

TREATMENT HISTORY

Please indicate treatment history

Adempas® (riociguat) Tablets	<input type="radio"/> Current	<input type="radio"/> Discontinued
Epoprostenol sodium for Injection	<input type="radio"/> Current	<input type="radio"/> Discontinued
Flolan® (epoprostenol sodium) for Injection	<input type="radio"/> Current	<input type="radio"/> Discontinued
Letairis® (ambrisentan) Tablets	<input type="radio"/> Current	<input type="radio"/> Discontinued
Opsumit® (macitentan) Tablets	<input type="radio"/> Current	<input type="radio"/> Discontinued
Orenitram® (treprostinil) Extended-Release Tablets	<input type="radio"/> Current	<input type="radio"/> Discontinued
PDE-5i (specify drugs):	<input type="radio"/> Current	<input type="radio"/> Discontinued
Remodulin® (treprostinil) Injection	<input type="radio"/> Current	<input type="radio"/> Discontinued
Tracleer® (bosentan) Tablets	<input type="radio"/> Current	<input type="radio"/> Discontinued
Tyvaso® (treprostinil) Inhalation Solution	<input type="radio"/> Current	<input type="radio"/> Discontinued
Tyvaso DPI® (treprostinil) Inhalation Powder	<input type="radio"/> Current	<input type="radio"/> Discontinued
Uptravi® (selexipag) Tablets	<input type="radio"/> Current	<input type="radio"/> Discontinued
Velettri® (epoprostenol) for Injection	<input type="radio"/> Current	<input type="radio"/> Discontinued
Ventavis® (iloprost) Inhalation Solution	<input type="radio"/> Current	<input type="radio"/> Discontinued
Other: _____	<input type="radio"/> Current	<input type="radio"/> Discontinued

TRANSITION STATEMENT

(if applicable)

It is necessary for this patient to transition

from:

to:

Please provide justification for this transition.

PRESCRIBER SIGNATURE

SIGN
HERE

Prescriber Signature

Prescriber Full Name (print)

Date

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 is not a guarantee of coverage or reimbursement.

Patient Name (first, MI, last)

Date of Birth

Prescriber Name (first, MI, last)

NPI #

CALCIUM CHANNEL BLOCKER STATEMENT

Indicate whether the patient named above was trialed on a calcium channel blocker prior to the initiation of therapy and provide the results.

A calcium channel blocker was not trialed because:

- ☐ Patient has depressed cardiac input
- ☐ Patient has systematic hypotension
- ☐ Patient has known hypersensitivity
- ☐ Patient is hemodynamically unstable or has a history of postural hypotension
- ☐ Patient did not meet ACCP Guidelines for Vasodilator Response
- ☐ Patient has documented bradycardia or second or third-degree heartblock
- ☐ Other: _____

The following calcium channel blocker was trialed:

The patient had the following response(s):

- ☐ Patient hypersensitive or allergic
- ☐ Adverse event
- ☐ Patient became hemodynamically unstable
- ☐ Pulmonary arterial pressure continued to rise
- ☐ Disease continued to progress, or patient remained symptomatic
- ☐ Other: _____

PRESCRIBER SIGNATURE

**SIGN
HERE**

Prescriber Signature

Prescriber Full Name (print)

Date

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 is not a guarantee of coverage or reimbursement.

Patient Name (first, MI, last)

Date of Birth

Prescriber Name (first, MI, last)

NPI #

PATIENT EVALUATION

Patient Status:

- ☐ Outpatient
☐ Inpatient

WHO Group:

NYHA Functional Class:

- ☐ I ☐ II ☐ III ☐ IV

YUTREPIA™ Status:

- ☐ Naïve / New
☐ Restart
☐ Transition

Diabetic?

- ☐ Yes
☐ No

Allergies:

- ☐ No known drug allergies (NKDA)
☐ Yes (specify): _____

Height:

Weight:

Date Taken:

cm kg
in lb

Current Medications (list all):

MEDICAL INFORMATION

REQUIRED: Please select one of the following ICD-10 codes, or Other ICD-10 code, as applicable. The following ICD-10 codes do not suggest approval, coverage, or reimbursement for specific uses or indications.

PH ☐ ICD-10 I27.23 Pulmonary hypertension due to lung diseases and hypoxia

Other ICD-10:

Code Description

ILD IIP:

- ☐ ICD-10 J84.10 Pulmonary fibrosis, unspecified
☐ ICD-10 J84.111 Idiopathic interstitial pneumonia, NOS
☐ ICD-10 J84.112 Idiopathic pulmonary fibrosis

CTD-related ILD:

- ☐ ICD-10 M34.81 Systemic sclerosis with lung involvement

Environmental/Occupational Lung Disease:

- ☐ ICD-10 J61 Pneumoconiosis due to asbestos and other mineral fibers
☐ ICD-10 J67.9 Hypersensitivity pneumonitis due to unspecified dust

Other causes:

- ☐ ICD-10 J17 Pneumonia in disease classified elsewhere

TRANSITION STATEMENT

(if applicable)

It is necessary for this patient to transition

from:

to:

Please provide justification for this transition.

TREATMENT HISTORY

Please indicate treatment history

Adempas® (riociguat) Tablets	<input type="radio"/> Current	<input type="radio"/> Discontinued
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Orenitram® (treprostinil) Extended-Release Tablets	<input type="radio"/> Current	<input type="radio"/> Discontinued
PDE-5i (specify drugs):	<input type="radio"/> Current	<input type="radio"/> Discontinued
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Tyvaso DPI® (treprostinil) Inhalation Powder	<input type="radio"/> Current	<input type="radio"/> Discontinued
Upravi® (selexipag) Tablets	<input type="radio"/> Current	<input type="radio"/> Discontinued
Velettri® (epoprostenol) for Injection	<input type="radio"/> Current	<input type="radio"/> Discontinued
Ventavis® (iloprost) Inhalation Solution	<input type="radio"/> Current	<input type="radio"/> Discontinued
Other: _____	<input type="radio"/> Current	<input type="radio"/> Discontinued

PRESCRIBER SIGNATURE

SIGN
HERE

Prescriber Signature

Prescriber Full Name (print)

Date

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Using this cover sheet, fax all pages of the enrollment form, along with the requested clinical documentation, 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

DOCUMENTATION CHECKLIST

Indicate all current, signed and dated documents enclosed with this fax.

- | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| <input type="radio"/> Completed YUTREPIA Enrollment Form, including: <ul style="list-style-type: none">– Patient/Insurance Information– Prescriber/Prescription Information– Medical Information/Patient Evaluation | <input type="radio"/> Echocardiogram
<i>(not required for PH-ILD patients)</i> |
| <input type="radio"/> Copy of front and back of patient's insurance card(s) | <input type="radio"/> 6-minute walk test results
<i>(not required for PH-ILD patients)</i> |
| <input type="radio"/> Right heart catheterization | <input type="radio"/> History and physical, including onset of symptoms, clinical signs and symptoms and course of illness |
| <input type="radio"/> High-resolution CT scan
<i>(not required for PAH patients)</i> | <input type="radio"/> Need for specific drug therapy |

Comments: