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

REMODULIN® (treprostinil) Injection

Remodulin 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 and Insurance Information. Let your patient know that an SPS provider will be calling, and it is important to answer or return the call.
- ☐ 3 Complete and sign the Prescriber Information, Prescription, Medical Information and Statement of Medical Necessity.
- ☐ 4 Complete and sign the Treatment History, Transition Statement, and Calcium Channel Blocker Statement.
- ☐ 5 Complete the Optional Side Effect Management page.
- ☐ 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 **Fax Cover Sheet** to fax the referral form and signed supporting documents to United Therapeutics Cares or your preferred SPS provider. (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.

REMODULIN® (treprostinil) Injection

Patient Name: _____ **Date of Birth:** _____

2 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: ☐ Home ☐ Cell ☐ Work | Alternate Telephone: ☐ Home ☐ Cell ☐ Work | Best Time to Call: ☐ Morning ☐ Afternoon ☐ Evening

Okay to leave a voicemail? ☐ Yes ☐ No

E-mail Address

Caregiver/Family Member | Caregiver Telephone: ☐ Home ☐ Cell ☐ Work | Caregiver Alternate Telephone: ☐ Home ☐ Cell ☐ Work

Caregiver E-mail Address | Caregiver Alternate E-mail Address | Okay to leave a voicemail? ☐ Yes ☐ No

2 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).

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Patient Name: _____ **Date of Birth:** _____

3 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

3 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
☐ Congenital Heart Disease
☐ Drugs/Toxins induced
☐ Portal Hypertension
☐ HIV
☐ 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.

3 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)
☐ Ambulatory IV Infusion Pumps for Remodulin (2)
☐ Remunity® Pump for Remodulin *(Remunity Pumps (2), Remotes, Batteries + Chargers)*:
☐ Patient Fill ☐ Specialty Pharmacy Fill

Please see the bottom of this section for Specialty Pharmacy fill information for Remunity.

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
☐ pH 12 Sterile Diluent for Injection
☐ Epoprostenol Sterile Diluent for Injection
☐ 0.9% Sodium Chloride for Injection
☐ Sterile Water 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.

3 PRESCRIBER SIGNATURE: PRESCRIPTION AND STATEMENT OF MEDICAL NECESSITY

SIGN HERE

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: _____ **Date:** _____

DAW

_____ **Dispense as Written**
_____ **Substitution Allowed**

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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4 TREATMENT HISTORY AND TRANSITION STATEMENT

Please indicate Treatment History and list other concurrent medications.

Medication	Current	Discontinued
PDE-5 i (specify drugs)		
Epoprostenol		
Flolan® (epoprostenol sodium) for Injection		
Letairis® (ambrisentan) Tablets		
Remodulin® (treprostinil) Injection		
Tracleer® (bosentan) Tablets		
Tyvaso® (treprostinil) Inhalation Solution		
Tyvaso DPI® (treprostinil) Inhalation Powder		
Veletri® (epoprostenol) for Injection		
Ventavis® (iloprost) Inhalation Solution		
Adempas® (riociguat) Tablets		
Opsumit® (macitentan) Tablets		
Orenitram® (treprostinil) Extended-Release Tablets		
Uptravi® (selexipag) Tablets		
Other		
Other		
Other		

Transition Statement

It is necessary for this patient (if applicable) to transition

FROM _____ **TO** _____

Please provide justification for this transition.

_____

_____

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4 CALCIUM CHANNEL BLOCKER STATEMENT

Please indicate below if the Patient named above was trialed on a Calcium Channel Blocker prior to the initiation of therapy and indicate the results.

A Calcium Channel Blocker was not trialed because:

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

OR

The following Calcium Channel Blocker was trialed:

_____

_____

With the following response(s):

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

4 PRESCRIBER SIGNATURE

SIGN HERE **Prescriber Name:** _____ **Prescriber Signature:** _____ **Date:** _____

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5 OPTIONAL SIDE EFFECT MANAGEMENT

By providing your side effect management strategies, SPS will be able to follow up with the patient should they experience side effects. Include directions to SPS for dosing in Step 3 of this form.

***INFORMATION PROVIDED BELOW IS NOT A PRESCRIPTION; RATHER, IF ADDITIONAL PRESCRIPTIONS ARE INTENDED, THEY SHOULD BE PROVIDED TO THE PATIENT SEPARATELY.**

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

Diarrhea: ☐ Loperamide _____ mg _____ Frequency ☐ Diphenoxylate/atropine **(separate Rx required)** ☐ Dicyclomine **(separate Rx required)**
☐ Probiotics ☐ Add fiber to diet ☐ Gluten free diet ☐ Other _____

SC Site Pain: Non-pharmacologic considerations: ☐ Hot or Cold compress ☐ Aloe Vera gel ☐ Arnica oil ☐ Dry catheter placement
☐ Other _____

Topical agents: Topical corticosteroids - select from list (**separate Rx may be required**) ☐ Hydrocortisone cream ☐ Triamcinolone acetonide cream
☐ Fluticasone propionate nasal spray ☐ Pimecrolimus cream

Other topical considerations: ☐ Diphenhydramine HCL ☐ Hemorrhoid ointment ☐ PLO gel ☐ Lidoderm 5% patches ☐ Capsaicin 8% patch

Oral agents: Antihistamines - select from list (**separate Rx may be required**)

H_1 blockers: ☐ Cetirizine hydrochloride ☐ Fexofenadine hydrochloride **H_2 blockers:** ☐ Famotidine

Pain relievers - select from list (**separate Rx may be required**): ☐ Acetaminophen ☐ Ibuprofen

Other considerations (**separate Rx may be required**): ☐ Gabapentin ☐ Tramadol ☐ Amitriptyline HCl ☐ Pregabalin ☐ Opioids

Additional Instructions:

Provide any additional instructions for SPS on preferred communication or managing other side effects.

_____

_____

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.

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Patient Name: _____ **Date of Birth:** _____

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: _____

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: _____

REMODULIN® (treprostinil) Injection

Fax the completed referral form and documentation to United Therapeutics Cares or the Specialty Pharmacy of your choice below.

8 FAX COVER SHEET

Date: _____

To: (check one)

☐ **United Therapeutics Cares**
Fax: 1-800-380-5294
Phone: 1-844-864-8437

☐ **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 who transmitted the facsimile/Prescription)

_____

Facility Name: _____

Fax: _____

Included in this fax:

☐ **Completed Remodulin Therapy Referral Form including**

- Step 2 - Patient Information and Insurance Information (including front and back copies of medical and prescription insurance card(s))
- Step 3 - Prescriber Information, Prescription, Medical Information and Statement of Medical Necessity
- Step 4 - Treatment History, Transition Statement, Calcium Channel Blocker Statement
- Step 5 - Optional Side Effect Management
- Step 6 - Patient Consent
- Step 7 - Patient Authorization To Share Health Information

☐ **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:

_____
_____
_____
_____
_____
_____

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**

United Therapeutics
A PUBLIC BENEFIT CORPORATION