Voucher Referral - Orenitram 90-Day Trial Program Enrollment Form

orenitram® treprostinil EXTENDED-RELEASE TABLETS

90-DAY TRIAL PROGRAM

PLEASE READ CAREFULLY

Please complete all sections of the form below and fax to ASSIST: 1-800-380-5294

Orenitram 90-Day Trial Program Terms & Conditions

The Orenitram 90-Day Trial Program ("Trial Program") is offered by United Therapeutics Corporation. To utilize this Trial Program, you must have a valid prescription for an FDA-approved use of Orenitram. There is no obligation to continue Orenitram after the 90-Day Trial Program. If the decision is made to continue therapy, a separate prescription must be written by your healthcare provider and dispensed by one of United Therapeutics Corporation's contracted specialty pharmacies, Accredo or CVS Specialty. Patients may be offered the Trial Program exclusively through their healthcare provider.

Terms and Conditions for Trial Program

By enrolling in the 90-Day Trial Program for Orenitram, you acknowledge that you currently meet the eligibility criteria and will comply with the Terms and Conditions described below:

1. Only new patients with a valid prescription for an FDA-approved use of Orenitram may use this Trial Program. This **Trial Program** is not valid for patients transitioning to Orenitram from Tyvaso or Remodulin. By enrolling in this Trial Program, you certify that: (a) you are not currently using and have not previously used Orenitram outside of the hospital setting (i.e. "Outpatient"), and (b) you are not currently taking an inhaled or infused prostacyclin. **2.** Patients are not eligible to start the Trial program in the hospital setting (i.e. "Inpatient"). **3.** Product cannot be shipped to a hospital, physician's office, etc. Product must be shipped directly to the patient. **4.** This offer is only valid for those patients 18 years and older. **5.** Only 1 enrollment per patient may be redeemed under this program; no photocopies or reproductions of the enrollment form will be accepted. **6.** Enrollment is valid for 90 days of Orenitram at no cost to the patient. **7. No claim for reimbursement for product dispensed pursuant to this Trial Program may be submitted, in whole or part, to any third-party payer, including a public or private payer. 8.** The prescription for the Trial Program cannot be submitted to count towards out of pocket costs under any prescription medicine plan. **9.** For Medicare patients, Trial Program product may not count towards "True Out-of-Pocket (TrOOP)" expenses. **10.** The Trial Program enrollment form will be accepted only at United Therapeutics Corporation's contracted pharmacy for this Program, Lash and Group. Offer not valid if submitted to any other pharmacy. **11.** This enrollment form is not transferable. It is illegal for any person to sell, purchase, or trade, or offer to sell, purchase, or trade or to counterfeit this voucher. **12.** This 90-Day Trial Program cannot be combined with any other rebate/coupon, free trial, or similar offer for the specified prescription. **13. This free trial is not health insurance**. **14.** United Therapeutics Corporation makes no express or implied guarantee that Orenitram will be covered by any third-party payer after the 90-day trial period. **15.** Offer good only in the United States and Puerto Rico. **16.** United Therapeutics Corporation reserves the right to rescind, revoke, or amend this free trial program at any time without notice.

STEP 1 - PATIENT INFORMATION AND AUTHORIZATION

A PATIENT INFORMATION

Name: First	Middle	Last
Date of Birth	Gender	SSN
Home Address		Do you reside in the United States: ☐ Yes or ☐ No
City	State	Zip
Shipping Address (if not home address)		
City	State	Zip
Telephone	Alternate Telephone	Best Time to Call
E-mail Address		
Caregiver/Family Member	Telephone	Alternate Telephone

STEP 2 - PATIENT FINANCIAL, INSURANCE INFORMATION AND CERTIFICATION

B ASSIST® PATIENT AUTHORIZATION

By signing below, I authorize my health care providers, including the pharmacies I use, and my health insurance plan(s) to disclose my personal health information, including information about my insurance, prescriptions and medical condition ("My Information") to United Therapeutics and its contractors and business partners, including the Access Solutions and Support Team (ASSIST) (collectively "United Therapeutics") to determine my eligibility for and administer the Orenitram voucher program.

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: _____

United Therapeutics CORPORATION

Voucher Referral - Orenitram 90-Day Trial Program Enrollment Form

orenitram® treprostinil EXTENDED-RELEASE TABLETS | 90-DAY TRIAL PROGRAM

▶ Patient Name: _____ Date of Birth: _____

STEP 3 - PRESCRIBER, MEDICAL AND PRESCRIPTION INFORMATION

C PRESCRIBER INFORMATION

Prescriber: First	Last	NPI #	
Facility Name	Group NPI # (if applicable)		
Address	City	State	Zip
Office Contact Name	Telephone	Fax	
E-mail Address	Preferred Method of Communication		

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

ORENITRAM® (treprostinil) Extended-Release Tablets

STRENGTHS (Prior authorizations may be required for each strength, and patient may need all strengths 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)

DOSAGE (TID dosing may reduce peak-to-trough pharmacokinetic fluctuations):

- ☐ Initiate at 0.125mg TID. Titrate by 0.125mg TID every 7 days until goal of at least 3mg TID is achieved

OR

- ☐ Initiate at _____mg TID. Titrate by _____mg TID every _____ days until goal dose of _____mg TID is achieved

OR

- ☐ Initiate at _____mg BID. Titrate by _____mg BID every _____ days until goal dose of _____mg BID is achieved

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

_____

DIRECTIONS: Take tablets by mouth with food
DISPENSE: Quantity sufficient for up to maximum allowable dose for One (1) month's supply. Refill _____Time(s)
For Orenitram dosing and titration information, please see the Dosage and Administration section of the Prescribing Information.
TheraCom 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. Non-compliance with state specific requirements could result in outreach to the Prescriber.

Nurse Visits

CHECK HERE

Please select an option:

- ☐ **Field RN Educators** to provide education on self-administration of Orenitram to include dose, titration, and side effect management

OR

- ☐ **Prescriber directed Field RN Educators visit(s) as detailed below:**

_____

OPTIONAL: SIDE EFFECT MANAGEMENT STRATEGIES

By providing your side effect management strategies below, the TheraCom Pharmacist will be able to discuss your orders with the patient regarding your directions for managing side effects. If dose increments are not tolerated, consider titrating slower. Be sure to include directions to TheraCom Pharmacy for dosing in section D of this form.

NOTE THAT ANY 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 ☐ Gabapentin **(separate Rx required)** ☐ NSAIDs **(separate Rx may be required)** ☐ Opioids **(separate Rx required)**
☐ Tramadol **(separate Rx required)** ☐ Other _____

Diarrhea

☐ Add fiber to diet ☐ Loperamide____mg___Frequency ☐ Diphenoxylate/Atropine **(separate Rx may be required)** ☐ Dicyclomine **(separate Rx required)**
☐ Other _____

Nausea

☐ Metoclopramide **(separate Rx required)** ☐ Ondansetron **(separate Rx required)** ☐ PPIs **(separate Rx may be required)** ☐ Prochlorperazine **(separate Rx required)**
☐ Promethazine **(separate Rx required)**
☐ Other _____

E PRESCRIBER SIGNATURE: PRESCRIPTION AND STATEMENT OF MEDICAL NECESSITY

I certify that the medication ordered above is for an FDA-approved indication, 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 Lash/TheraCom Pharmacy.

PRESCRIBER SIGNATURE REQUIRED TO VALIDATE PRESCRIPTIONS.

SIGN HERE

Prescriber signature _____ **Date**_____ ☐ Dispense as written ☐ Substitution allowed

Collaborating Physician Name_____

(Prescriber attests this is his/her legal signature. NO STAMPS.)

United Therapeutics CORPORATION