Referral Form for REMODULIN

REMODULIN® (treprostinil) Injection

Remodulin is available only through select Specialty Pharmacy Services (SPS) providers.

Follow these 5 steps to complete each section of the following referral form.

GET STARTED CHECKLIST

- ☐ 1 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.
- ☐ 2 Complete and sign the Prescriber Information, Prescription, Medical Information and Statement of Medical Necessity.
- ☐ 3 Complete and sign the Treatment History, Transition Statement, and Calcium Channel Blocker Statement.
- ☐ 4 Complete the Optional Side Effect Management page.
- ☐ 5 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 your SPS provider. (Note: Insurance plans vary and may impact the approval process.)

STEP 1 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(s) to Call: ☐ Morning ☐ Afternoon ☐ Evening

E-mail Address

Caregiver/Family Member | Caregiver E-mail Address

Caregiver Telephone: ☐ Home ☐ Cell ☐ Work | Caregiver Alternate Telephone: ☐ Home ☐ Cell ☐ Work | Okay to Leave a Message? ☐ Yes ☐ No

STEP 1 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).

United Therapeutics Remodulin (treprostinil) Referral Form

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

STEP 2 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

STEP 2 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 ☐ Portal Hypertension
☐ Congenital Heart Disease ☐ HIV
☐ Drugs/Toxins induced ☐ 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)

STEP 2 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 the page for Specialty Pharmacy fill information.

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.

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.

STEP 2 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.

United Therapeutics Remodulin (treprostinil) Referral Form

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

STEP 3 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		
Veletri® (epoprostenol) for Injection		
Ventavis® (iloprost) Inhalation Solution		
Adempas® (riociguat) Tablets		
Opsumit® (macitentan) Tablets		
Orenitram® (treprostinil) Extended-Release		
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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STEP 3 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 has systemic 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 heart block
- ☐ Other: _____

OR

The following Calcium Channel Blocker was trialed:

_____

_____

With the following response(s):

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

STEP 3 PRESCRIBER SIGNATURE

SIGN HERE

Prescriber Name: _____ **Prescriber Signature:** _____ **Date:** _____

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

STEP 4 OPTIONAL SIDE EFFECT MANAGEMENT

Be sure to include directions to SPS for dosing in step 2 of this form. Remodulin is preferably infused subcutaneously but can be administered by a central venous line if the subcutaneous (SC) route is not tolerated because of severe site pain or reaction. In addition to the options listed below, patients can consider alternating SC site location (upper buttocks, back of arms, flanks, abdomen), trying alternative SC catheter (Cleo, Silhouette, Quick Set), as well as maintaining a 'good' site for several weeks.

***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 may be required)** ☐ Gabapentin **(separate Rx required)**
☐ Opioids **(separate Rx 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

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Additional Instructions:

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

_____
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Fax the completed referral form and documentation to the specialty pharmacy of your choice below.

STEP 5 FAX COVER SHEET

Date: _____

To: (check one)

☐ **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 1 - Patient Information/Insurance Information (Including front and back copies of insurance card)
- Step 2 - Prescriber/Prescription Information/Medical Information/Patient Evaluation
- Step 3 - Treatment History/Transition Statement and Calcium Channel Blocker Statement
- Step 4 - Optional Side Effect Management

☐ **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:

_____
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US-REM-0825

United Therapeutics CORPORATION