

# United Therapeutics Remodulin® (treprostinil) or Tyvaso® (treprostinil) VA Referral Form 1

**ACCREDITO**  
FAX: 1-800-711-3526  
PHONE: 1-866-344-4874

**CVS/CAREMARK**  
FAX: 1-877-943-1000  
PHONE: 1-877-242-2738

## A PATIENT INFORMATION

Name: First	Middle	Last
Date of Birth	Gender	
Home Address		
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

## B VA PHARMACY INFORMATION

Name of VA facility: \_\_\_\_\_

Address: \_\_\_\_\_ Suite: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Contact name: \_\_\_\_\_ Contact phone #: \_\_\_\_\_ Contact fax #: \_\_\_\_\_

Ship to address: \_\_\_\_\_ Suite: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Purchase #: \_\_\_\_\_ Ship to:  Patient  VA location

## C MEDICAL INFORMATION / PATIENT EVALUATION

Patient UT PAH Product Therapy Status for the requested drug <input type="checkbox"/> Naive/New <input type="checkbox"/> Restart <input type="checkbox"/> Transition			Current Specialty Pharmacy <input type="checkbox"/> Accredo <input type="checkbox"/> CVS Caremark		Patient Status <input type="checkbox"/> Outpatient <input type="checkbox"/> Inpatient		Allergies <input type="checkbox"/> Yes <input type="checkbox"/> No If yes _____	
WHO Group	NYHA Functional Class <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV		Weight _____ kg/lb	Height _____	Diabetic <input type="checkbox"/> Yes <input type="checkbox"/> No			

**Diagnosis - The following ICD-10 codes**  
ICD-10 I27.0 Primary pulmonary hypertension  
 Idiopathic PAH  Heritable PAH  Other \_\_\_\_\_

**Tyvaso® (treprostinil) Inhalation Solution,  
Remodulin® (treprostinil) Injection**

# United Therapeutics Remodulin® (treprostinil) or Tyvaso® (treprostinil) VA Referral Form <sup>2</sup>

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For Patient: \_\_\_\_\_

DOB: \_\_\_\_\_

## D PRESCRIBER INFORMATION

Prescriber: First	Last	
NPI #	State License #	
Facility Name		
Address		
City	State	Zip
Office Contact Name	Telephone	Fax
E-mail Address	Preferred Method of Communication	

## E PRESCRIPTION INFORMATION

### TYVASO® (treprostinil) Inhalation Solution

Target dose: 9 breaths (54 mcg) 4 times a day—Start with 3 breaths (18 mcg) 4 times a day (if 3 breaths are not tolerated, use 1 to 2 breaths).

Increase by additional 3 breaths at 1- to 2-week intervals, if tolerated, until the target dose of 9 breaths (54 mcg) 4 times a day.

**Quantity:**  TYVASO Inhalation System Starter Kit (28-day supply)  TYVASO Inhalation System Refill Kit (28-day supply) X \_\_\_\_\_ refills

### REMODULIN® (treprostinil) Injection

**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

Prescribing practitioner to specify infusion type by checking the box below:  Subcutaneous continuous infusion  Intravenous continuous infusion

### Dosing and Titration Instructions

For Remodulin dosing and titration information, please see the Dosage and Administration section of the Prescribing Information.

To specify initial dosing and titration instructions, fill in the blanks OR use the lines below.

Initiation dosage: \_\_\_\_\_ ng/kg/min Titrate by \_\_\_\_\_ ng/kg/min every \_\_\_\_\_ days until goal of \_\_\_\_\_ ng/kg/min is achieved

Prescribing practitioner may specify any alternative or additional dosing and titration instructions here (above fields may be left blank if preferred): \_\_\_\_\_

Specialty Pharmacy to contact prescribing practitioner for adjustments to the written orders specified above. \_\_\_\_\_

**Central venous catheter care:**  Dressing change every \_\_\_\_\_ days  Per IV standard of care

### Check one:

0.9% Sodium Chloride for Injection  Remodulin® Sterile Diluent for Injection  Sterile Water for Injection  Epoprostenol Sterile Diluent for Injection

**Pumps:**  2 CADD-MS® 3 Pumps  2 CADD-Legacy® Pumps

### Nurse Visits (Optional)

Please select an option:

Specialty Pharmacy home healthcare RN visit(s) to provide education on self-administration of Remodulin and Tyvaso to include dose and titration

OR

Prescriber directed Specialty Pharmacy home healthcare RN visit(s) as detailed below: \_\_\_\_\_

CHECK  
HERE

## F PRESCRIBER SIGNATURE: PRESCRIPTION AND STATEMENT OF MEDICAL NECESSITY

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 SIGNATURE REQUIRED TO VALIDATE PRESCRIPTIONS.

Physician's signature \_\_\_\_\_ Dispense as Written \_\_\_\_\_ Substitution Allowed \_\_\_\_\_ Date \_\_\_\_\_

SIGN  
HERE

(Physician attests this is his/her legal signature. NO STAMPS.) PRESCRIPTIONS MUST BE FAXED.