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

ACCREDO
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
☐ Naïve/New ☐ Restart ☐ Transition

Current Specialty Pharmacy
☐ Accredo ☐ CVS Caremark

Patient Status
☐ Outpatient ☐ Inpatient

Allergies
☐ Yes ☐ No If yes _____

WHO Group

NYHA Functional Class
☐ I ☐ II ☐ III ☐ IV

Weight _____ kg/lb Height _____ Diabetic ☐ Yes ☐ No

Diagnosis - The following ICD-10 codes

ICD-10 I27.0 Primary pulmonary hypertension

☐ Idiopathic PAH ☐ Heritable PAH ☐ Other _____

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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)

CHECK HERE

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:**

_____

_____

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.

SIGN HERE

PHYSICIAN SIGNATURE REQUIRED TO VALIDATE PRESCRIPTIONS.

Physician's signature _____ _____ Date _____

Dispense as Written **Substitution Allowed**

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