Synergen Rx LLC
3990 Flowers Road Suite 530
Doraville GA 30360

Phone: 404-585-7517 Fax 404-900-9209

Please Include the following chart notes and/or labs where applicable and fax the referral form with documents to 404-900-9209.

- Right Heart Catheterization Results
- Echocardiogram Results
- 6-minute Walk Test Results
- WHO Group Classification
- NYHA Class
- Previous tried and failed Medications

Orenitram® (treprostinil) Extended-Release Tablets Referral Form

Please complete, sign, and fax Steps 1 and 2 to ASSIST using the included Fax Cover Sheet.

orenitram® treprostinil EXTENDED-RELEASE TABLETS

STEP 1 - PATIENT INFORMATION AND AUTHORIZATION

A PATIENT INFORMATION

Name: First	Middle	Last
Date of Birth	Gender	Last 4 digits of SSN
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 INSURANCE INFORMATION

Pharmacy Benefits Manager:		
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 Insurance Card(s).

C PATIENT AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize my health care providers, including my pharmacies and health plan(s) ("Health Care Providers") to disclose my personal information, including information about my insurance, prescriptions, medical condition and health ("Information") to United Therapeutics and its contractors and business partners (including the Access Solutions and Support Team [ASSIST]) (collectively "United Therapeutics") for the following purposes:

(1) to verify, investigate, and assist with the coordination of my coverage for United Therapeutics products; (2) facilitate my access to prescribed United Therapeutics products; (3) contact me to discuss available patient support programs; (4) determine my initial and continuing eligibility for assistance programs; (5) provide educational information and promotional materials related to United Therapeutics products or my condition or treatment; (6) internal review by United Therapeutics of its programs for continuous improvement; and (7) use my deidentified information for ongoing analysis and quality improvement for United Therapeutics medicines.

Certain Health Care Providers may receive payment from United Therapeutics in exchange for disclosing my Information as described above and/or for using my information to contact me about United Therapeutics products and other support programs.

I understand that federal privacy laws may not protect my Information once it is disclosed; however, United Therapeutics agrees to protect my Information by using and disclosing it only for the purposes specified. **I understand that I may refuse to sign the authorization and that this refusal will not affect my treatment, insurance coverage, or eligibility for benefits. However, if I do not sign, I may not be eligible to receive education and patient support services provided by United Therapeutics.**

This authorization will expire in ten (10) years after the date it is signed unless a shorter period is mandated by state law or I revoke or cancel my authorization before then. I understand that I may cancel this authorization at any time by fax at 1-800-380-5294 or by writing to: United Therapeutics Corporation ASSIST, 1130 S. Harbor City Blvd., Suite 103, Melbourne, Florida 32901, but the cancellation will not apply to information that Health Care Providers have previously disclosed in reliance on this authorization. I understand that I am entitled to receive a copy of this authorization once signed.

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:_____

ORENITRAM PATIENT SUPPORT PROGRAM

By checking the box below, I agree to be enrolled in the Orenitram Patient Support Program which includes receiving information and promotions from United Therapeutics regarding programs and services related to my condition, including treatment information. Information sent by United Therapeutics does not take the place of talking to your healthcare provider about your treatment or condition. **United Therapeutics, or third parties working on its behalf, will not sell your information or use it for any unrelated purposes.** If, in the future, you no longer want to receive these materials or participate in these programs, please call 1-877-864-8437. Please visit Orenitram.com to review our Privacy Notice.

CHECK HERE

☐ **By checking this box, I agree to be enrolled in the Orenitram Patient Support Program.**

Please note: United Therapeutics cannot guarantee payment for United Therapeutics products and directs patients to discuss treatment options with their healthcare provider.

United Therapeutics CORPORATION

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orenitram® treprostinil EXTENDED-RELEASE TABLETS

PATIENT NAME: _____ **DATE OF BIRTH:** _____

STEP 2 - PRESCRIBER, MEDICAL AND PRESCRIPTION INFORMATION

D PRESCRIBER INFORMATION

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

E MEDICAL INFORMATION / PATIENT EVALUATION / SUPPORTING DOCUMENTATION

Patient UT PAH Product Therapy Status for the requested drug ☐ Naive/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 do not suggest approval, coverage or reimbursement for specific uses or indications

ICD-10 I27.0 Primary pulmonary hypertension
☐ Idiopathic PAH ☐ Heritable PAH

ICD-10 I27.2 Other chronic pulmonary heart diseases: pulmonary arterial hypertension, secondary
☐ Connective Tissue Disease ☐ Congenital Heart Disease ☐ Portal Hypertension
☐ Drugs/Toxins Induced ☐ HIV ☐ Other _____

Other ICD-10 _____

List PAH-specific medications patient is taking or has taken _____

F 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 I **DISPENSE:** Quantity sufficient for up to maximum allowable dose for one (1) month's supply. Refills _____12 Months
OR Refills _____Time For Orenitram dosing and titration information, please see the Dosage and Administration section of the Prescribing Information.

Specialty 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. Noncompliance with state-specific requirements could result in outreach to the Prescriber.

Nurse Visits

CHECK HERE

Please select an option:

☐ **Specialty Pharmacy home healthcare RN visit(s)** to provide education on self-administration of Orenitram to include dose, titration, and side effect management (see page 4/next page)

OR

☐ **Prescriber-directed Specialty Pharmacy home healthcare RN visit(s) as detailed below:**

_____

_____

G PRESCRIBER SIGNATURE: PRESCRIPTION AND STATEMENT OF MEDICAL NECESSITY

I certify that the medication ordered above 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 appropriate pharmacy designated by the Patient utilizing their benefit plan.

SIGN HERE

PHYSICIAN SIGNATURE REQUIRED TO VALIDATE PRESCRIPTIONS.

Physician's signature_____ **Physician's signature**_____ **Date**_____

Dispense as Written Substitution Allowed

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

Please note: The responsibility to determine coverage and reimbursement parameters, and appropriate coding for a particular patient and/or procedure, is the responsibility of the provider. The information provided here, or through ASSIST, is not a guarantee of coverage or reimbursement.

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PATIENT NAME: _____ **DATE OF BIRTH:** _____

OPTIONAL: SIDE EFFECT MANAGEMENT STRATEGIES

By providing your side effect management strategies below, SPS will be able to follow up 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 SPS for dosing in section F 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 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 _____

ADDITIONAL INSTRUCTIONS

Provide any additional instructions for SPS on preferred communication or managing other side effects (eg, flushing, pain in jaw, pain in extremity, hypokalemia, abdominal discomfort).

_____

_____

_____

_____

_____

NOTE: SPS offers additional in-home nurse visits on request.

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