

# United Therapeutics TYVASO® (treprostinil) and TYVASO DPI® (treprostinil) VA Referral Form



Prescriber: Please forward this completed form to the VA Pharmacy. The VA Pharmacy will fax the completed form to Accredro at Fax: 1-800-711-3526, Phone: 1-866-344-4874 or CVS Specialty at Fax: 1-877-943-1000, Phone: 1-877-242-2738.

## STEP 1 PATIENT INFORMATION

Name: First	Middle	Last
Date of Birth	Gender	Preferred Language
Home Address		
City	State	Zip
Shipping Address (if different from home address)		
City	State	Zip
Telephone <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	Alternate Telephone <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	Best Time to Call <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Anytime
E-mail Address		
Caregiver/Family Member	Caregiver Telephone <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	Caregiver Alternate Telephone <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work
Caregiver E-mail Address	Caregiver Alternate E-mail Address	

## STEP 2 VA PHARMACY INFORMATION

Name of VA Facility					
Address	Suite	City	State	City	Zip
Primary Purchasing Contact Name	Telephone	Fax	E-mail		
Primary Clinical Contact Name	Telephone	Fax	E-mail		
Secondary Purchasing Contact Name	Telephone	Fax	E-mail		
Secondary Clinical Contact Name	Telephone	Fax	E-mail		
Payment Method <input type="checkbox"/> Credit Card (call pharmacy contact) <input type="checkbox"/> E-invoice Tungsten Network	Purchase Order #		Ship to <input type="checkbox"/> Patient <input type="checkbox"/> VA Location		

## STEP 3 PRESCRIBER INFORMATION

Prescriber: First	Last	
NPI#	State License #	
Facility Name	MD Specialty	
Address		
City	State	Zip
Office Contact Name	Telephone	Fax
E-mail Address	Preferred Method of Communication <input type="checkbox"/> Phone <input type="checkbox"/> E-mail <input type="checkbox"/> Mail <input type="checkbox"/> Fax	
PCP (if different from prescribing MD)	PCP Phone	




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Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**STEP 5 PAH - USE THIS SECTION FOR PAH**

<b>Patient Product Therapy Status for the Requested Drug:</b> <input type="checkbox"/> Naïve/New <input type="checkbox"/> Restart <input type="checkbox"/> Transition		<b>Current Specialty Pharmacy:</b> <input type="checkbox"/> Accredo Health Group, Inc. <input type="checkbox"/> CVS Specialty		<b>Patient Status:</b> <input type="checkbox"/> Outpatient <input type="checkbox"/> Inpatient		<b>WHO Group:</b> _____	
<b>NYHA Functional Class:</b> <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV		<b>Weight:</b> _____ <input type="checkbox"/> kg <input type="checkbox"/> lb <b>Height:</b> _____ft _____in		<b>Diabetic:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Allergies:</b> <input type="checkbox"/> Drug Allergies <input type="checkbox"/> Non-Drug Allergies <input type="checkbox"/> No Known Allergies	




**TYVASO (treprostinil) 1.74mg/2.9ml ampule (0.6mg/ml) Inhalation Solution**  
**Target dose: 9 breaths (54 mcg) to 12 breaths (72 mcg), 4 times daily** - Start with 3 breaths (18 mcg) 4 times daily (if 3 breaths are not tolerated, use 1 to 2 breaths). Increase by an additional 3 breaths per week, if tolerated, until the target dose of 9 breaths (54 mcg) to 12 breaths (72 mcg), 4 times daily.

TYVASO Inhalation System Starter Kit (28-day supply) 0 refills  
 TYVASO Inhalation System Refill Kit (28-day supply) X \_\_\_\_\_ refills

The medication cost does not include the nebulizer device and supplies. Those are provided at an additional charge.

**Prescriber may specify any alternative or additional dosing and titration instructions here:**

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**OR**

**TYVASO DPI (treprostinil) Inhalation Powder**  
**Target dose:  48 mcg or  64 mcg or  Other \_\_\_\_\_ mcg per treatment session, 4 times daily (Check One)**  
 Start with one 16-mcg cartridge per treatment session, 4 times daily. Increase cartridge strength by 16 mcg per treatment session every week to selected target dose. Titration schedule may vary based on tolerability. If the prescribed dose is higher than 64 mcg per treatment session, more than 1 cartridge will be needed per session.

**TYVASO DPI Titration Kit (28-day supply) Choose one for titration phase.**  
 16 mcg (112 ct) and 32 mcg (84 ct) 0 refills  
 16 mcg (112 ct), 32 mcg (112 ct), and 48 mcg (28 ct) 0 refills

**TYVASO DPI Maintenance Kit (28-day supply) X \_\_\_\_\_ refills**  
**Inhale one breath per cartridge, 4 times daily. Please check all boxes to allow maintenance dose at the highest dose tolerated, unless otherwise specified.**  
 16 mcg (112 ct)     32 mcg (112 ct)     48 mcg (112 ct)     64 mcg (112 ct)     80 mcg combination: 32 mcg (112 ct) and 48 mcg (112 ct)

**Prescriber may specify any alternative or additional dosing and titration instructions here. If the prescribed dose is higher than 64 mcg per treatment session, more than 1 cartridge will be needed per session:**

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

**Dose Comparison**

TYVASO Nebulizer # of Breaths	TYVASO DPI Cartridge Strength
≤5	16 mcg
6 to 7	32 mcg
8 to 10	48 mcg
11 to 12	64 mcg
~15	80 mcg

**NURSING ORDERS**

Please check this box if you would like your patient to receive nurse-supported\* patient education for Tyvaso and/or Tyvaso DPI administration. Nurse support\* is available to patients who are learning to administer their Tyvaso therapy.

Note: Order for this drug is not inclusive of skilled nursing home health services. To request skilled nursing services for home inhalation therapy, the referring VA provider should enter a COMMUNITY CARE-GEC SKILLED HOME CARE consult. The VA facility community care office will coordinate the requested service through CCN (Community Care Network) or VCA (Veteran Care Agreement) as appropriate.

\*Nurse support is limited to education for patients and their United Therapeutics therapy, its administration, and/or their disease. It is intended to supplement a patient's understanding of their therapy, and is not intended to provide medical advice, replace a treatment plan from the patient's doctor or nurse, directly provide case management services, or serve as a reason to prescribe. Program rules and limitations will apply.

**STEP 5 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: \_\_\_\_\_ Dispense as Written \_\_\_\_\_ Substitution Allowed \_\_\_\_\_ Date: \_\_\_\_\_

**DAW** → State-Specific Dispense as Written (DAW) Selection Verbiage: \_\_\_\_\_

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