# SPmix Enrollment Form for REMODULIN® (treprostinil) Injection
# United Therapeutics Corporation Therapy Enrollment Form

**Please complete, sign, and fax Steps 1 and 2, along with requested clinical documentation, to your preferred Specialty Pharmacy using the included Fax Cover Sheet.**

## STEP 1 - PATIENT INFORMATION

### A 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 | Alternate Telephone | Best Time to Call

☐ Morning ☐ Afternoon ☐ Evening ☐ Anytime

E-mail Address | Cell Phone

Caregiver/Family Member | Telephone | Alternate Telephone

☐ **By checking this box I authorize SPS to leave a message with a caregiver/family member.**

### 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 medical and prescription insurance card(s).**

***Please Note: Each practitioner is solely responsible for ensuring the accuracy of the information submitted. State- and Payer-specific requirements may vary.***



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

## STEP 2 - PRESCRIBER INFORMATION AND PRESCRIPTION INFORMATION

### C PRESCRIBER INFORMATION

Prescriber Name: First Last NPI # State License #

Office/Clinic/Institution name TIN #

Address City State Zip

Office Contact Name Telephone Fax

E-mail Address Preferred Method of Communication ☐ Phone ☐ Email ☐ Mail ☐ Fax

### D MEDICAL INFORMATION / PATIENT EVALUATION

**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 I27.21 Secondary pulmonary arterial hypertension:
☐ Connective tissue disease ☐ Congenital Heart Disease ☐ Portal Hypertension
☐ Drugs/Toxins induced ☐ HIV ☐ Other: _____

Other ICD-10: _____

Allergies: ☐ Yes ☐ No ☐ No Known Drug Allergies
If yes _____

Weight:_____ ☐ kg ☐ lb
Height: _____ ft _____ in

Diabetic: ☐ Yes ☐ No

### E PRESCRIPTION INFORMATION

☐ **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)

Refills 1 year or _____ **Patient dosing weight:** _____ ☐ kg ☐ lb

**Diluent:** Remodulin® Sterile Diluent for Injection

**Infusion Type:** ☐ **Intravenous continuous infusion**

**Dosing and Titration Instructions:** *For Remodulin dosing and titration information, please see the Dosage and Administration section of the Prescribing Information.*

Specify Current Dose:_____ Concentration: _____ Pump rate:_____

- Dispense 1 week of Remodulin (treprostinil) premixed cassettes containing prescribed concentration (compounded by specialty pharmacy per USP 797 guidelines), ancillary supplies, and medical equipment necessary to administer medication. Cassette to be changed 48 hours after infusion start or as directed.
- Dispense 1 week of Remodulin (treprostinil) for emergency supply, and quantity sufficient of prescribed diluent, syringes, needles, and any other necessary supplies to mix and administer for emergency supply.
- Dispense teaching kits (diluent, syringes, needles, and any other necessary supplies to mix and assess patient's mixing skills). Quantity: up to 4 kits per quarter and refill ×1 year.
- Dispense 1-month of needles, syringes, ancillary supplies, and medical equipment necessary to administer medication.

**Central Venous Catheter Care:** ☐ Dressing change every _____ days ☐ Per IV standard of care

**Pumps:** ☐ Ambulatory IV Infusion Pumps for Remodulin (2)

**Nursing Orders - RN visits to provide assessment and education on administration, dosing, titration and transitioning to pre-mix cassettes with the use of teaching kits**

☐ quarterly or ☐ every 6 months

**The Prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the Prescriber.**

### 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 who has been on Remodulin IV for the past 3 months and a steady dose for at least 1 month. I authorize United Therapeutics Corporation, its affiliates, agents, and contractors (collectively, United Therapeutics) 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.**
**PHYSICIAN SIGNATURE REQUIRED TO VALIDATE PRESCRIPTIONS.**

SIGN HERE

**Physician's Signature:** _____ _____ **Date:** _____
**Dispense as Written** **Substitution Allowed**

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



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## STEP 3 - FAX

# FAX COVER SHEET

**Date**:

**To**:

☐ **Accredo Health Group, Inc.**
**Fax: 1-800-711-3526**
**Phone: 1-866-344-4874**

☐ **CVS Specialty**
**Fax: 1-800-943-1000**
**Phone: 1-877-242-2738**

**From**:

**Facility Name**:

**Fax**:

**Included in this fax:**

☐ **Completed SPmix Enrollment Form including**
- ☐ Page 1 - Patient/Insurance Information
- ☐ Page 2 - Prescriber/Prescription Information

☐ **Medication History**

**Number of Pages**:

**Comments**:

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