Orenitram® 90-Day Trial Program Enrollment Form

Please complete all sections of the form below and fax to United Therapeutics Cares™: 1-800-380-5294

orenitram treprostinil EXTENDED-RELEASE TABLETS | 90-DAY TRIAL PROGRAM

PLEASE READ CAREFULLY

Orenitram 90-Day Trial Program Terms & Conditions

The Orenitram 90-Day Trial Program ("Trial Program") is offered by United Therapeutics Corporation. To utilize this Trial Program, you must have a valid prescription for an FDA-approved use of Orenitram. There is no obligation to continue Orenitram after the 90-Day Trial Program. If the decision is made to continue therapy, a separate prescription must be written by your healthcare provider and dispensed by one of United Therapeutics Corporation's contracted specialty pharmacies, Accredo or CVS Specialty. Patients may be offered the Trial Program exclusively through their healthcare provider.

Terms and Conditions for Trial Program

By enrolling in the 90-Day Trial Program for Orenitram, you acknowledge that you currently meet the eligibility criteria and will comply with the Terms and Conditions described below:

1. Only new patients with a valid prescription for an FDA-approved use of Orenitram may use this Trial Program. This Trial Program is not valid for patients transitioning to Orenitram from Tyvaso or Remodulin. By enrolling in this Trial Program, you certify that: (a) you are not currently using and have not previously used Orenitram, and (b) you are not currently taking an inhaled or infused prostacyclin. **2.** Patients are not eligible to start the Trial program in the hospital setting (i.e. Inpatient). **3.** Product cannot be shipped to a hospital, physician's offce, etc. Product must be shipped directly to the patient. **4.** This offer is only valid for those patients 18 years and older. **5.** Only 1 enrollment per patient may be redeemed under this program; no photocopies or reproductions of the enrollment form will be accepted. **6.** Enrollment is valid for 90 days of Orenitram at no cost to the patient. **7.** No claim for reimbursement for product dispensed pursuant to this Trial Program may be submitted, in whole or part, to any third-party payer, including a public or private payer. **8.** The prescription for the Trial Program cannot be submitted to count towards out of pocket costs under any prescription medicine plan. **9.** For Medicare patients, Trial Program product may not count towards "True Out-of-Pocket" (TrOOP) expenses. **10.** The Trial Program enrollment form will be accepted only at United Therapeutics Corporation's contracted pharmacy for this Program, Lash and Group. Offer not valid if submitted to any other pharmacy. **11.** This enrollment form is not transferable. It is illegal for any person to sell, purchase, or trade, or offer to sell, purchase, or trade or to counterfeit this voucher. **12.** This 90-Day Trial Program cannot be combined with any other rebate/coupon, free trial, or similar offer for the specified prescription. **13.** This free trial is not health insurance. **14.** United Therapeutics Corporation makes no express or implied guarantee that Orenitram will be covered by any third-party payer after the 90-day trial period. **15.** Offer good only in the United States and Puerto Rico. **16.** United Therapeutics Corporation reserves the right to rescind, revoke, or amend this free trial program at any time without notice.

1 PATIENT INFORMATION AND AUTHORIZATION

* Name: First _____ * Middle _____ * Last _____

* Date of Birth _____ Gender _____ * Last 4 Digits of SSN _____ E-mail Address _____

* Home Address _____ * City _____ * State _____ * Zip _____

Shipping Address (if different from home address) _____ City _____ State _____ Zip _____

* Telephone: ☐ Home ☐ Cell ☐ Work _____ Alternate Telephone: ☐ Home ☐ Cell ☐ Work _____ Best Time to Call: ☐ Morning ☐ Afternoon ☐ Evening ☐ Anytime

Caregiver/Family Member _____ Caregiver E-mail Address _____

* Caregiver Telephone: ☐ Home ☐ Cell ☐ Work _____ Alternate Telephone: ☐ Home ☐ Cell ☐ Work _____ OK to leave a message? ☐ Yes ☐ No

2 UNITED THERAPEUTICS CARES™ PATIENT AUTHORIZATION

By signing below, I authorize my health care providers, including the pharmacies I use, to disclose my personal health information, including information about prescriptions and medical condition ("My Information") to United Therapeutics and its contractors and business partners, including United Therapeutics Cares (collectively "United Therapeutics") to determine my eligibility for and to administer the Orenitram voucher program.

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 :_____

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Patient Name: _____ Date of Birth: _____

3 PRESCRIBER INFORMATION

* Name: First * Last * NPI #

_____

* Office/Clinic/Institution Name Group NPI # (if applicable)

_____

* Address * City * State * Zip

_____

* Office Contact Name * Telephone * Fax

_____

Office Contact E-mail Address

_____

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

4 PRESCRIPTION INFORMATION (the prescription is only valid if received by fax)

Initial Titration

☐ **Titration Kit (3-month supply); 0 Refills**
Month 1 (NDC 66302-361-28), 126 tablets of 0.125 mg and 42 tablets of 0.25 mg
Month 2 (NDC 66302-362-56), 126 tablets of 0.125 mg and 210 tablets of 0.25 mg
Month 3 (NDC 66302-363-84), 126 tablets of 0.125 mg, 42 tablets of 0.25 mg and 84 tablets of 1 mg

Directions: Initiate at 0.125mg TID. Titrate by 0.125mg TID every 7 days until a dose of 1.5mg TID is achieved by end of titration pack month 3.

OR Alternate Dosing Instructions (please select strengths to the right)

☐ Initiate at _____ mg ☐ **TID** OR ☐ **BID** (choose one). Titrate by _____ mg every ____ days until goal dose of _____ mg is achieved.

*** STRENGTHS** (Prior authorizations may be required for each strength. Select all appropriate strengths needed 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)

PRESCRIBER TO SPECIFY ANY ALTERNATIVE OR ADDITIONAL DOSING AND TITRATION INSTRUCTIONS HERE: _____

_____

_____

* **DISPENSE:** Quantity sufficient for up to maximum allowable dose for one (1) month's supply. **Refills** _____ time(s)

DIRECTIONS: Take tablets by mouth with food

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

TheraCom 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:

CHOOSE ONE

☐ **OPTION 1: Field RN Educators** to provide education on self-administration of Orenitram to include dose, titration, and side effect management

☐ **OPTION 2: Prescriber-directed Field RN Educators visit(s) as detailed:** _____

OPTIONAL SIDE EFFECT MANAGEMENT

Provide any additional instructions for TheraCom Pharmacy on preferred communication or managing other side effects (e.g., diarrhea, headache, nausea, etc.).

_____

_____

5 PRESCRIBER SIGNATURE: PRESCRIPTION AND STATEMENT OF MEDICAL NECESSITY

I certify that the medication ordered above is for an FDA-approved indication, is medically necessary, and that I am personally supervising the care of this patient. I authorize United Therapeutics Cares to act on my behalf for the limited purposes of transmitting this prescription to the Lash/TheraCom Pharmacy.

SIGN HERE

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

Collaborating Physician Name: _____

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