Referral Form for REMODULIN

Remodulin is available only through select Specialty Pharmacy Services (SPS) providers.

Follow these 5 steps to complete each section of the following referral form.

GET STARTED CHECKLIST

1. Fill out the Patient and Insurance Information. Let your patient know that an SPS provider will be calling, and it is important to answer or return the call.
2. Complete and sign the Prescriber Information, Prescription, Medical Information and Statement of Medical Necessity.
3. Complete and sign the Treatment History, Transition Statement, and Calcium Channel Blocker Statement.
4. Complete the Optional Side Effect Management page.
5. Attach the clinical documents outlined on the **fax cover sheet**, including right heart catheterization test results, history and physical, and echocardiogram results. Use the **fax cover sheet** to fax the referral form and signed supporting documents to your preferred SPS provider. (Note: Insurance plans vary and may impact the approval process.)

STEP 1 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: Home Cell Work | Alternate Telephone: Home Cell Work | Best Time(s) to Call: Morning Afternoon Evening

E-mail Address

Caregiver/Family Member | Caregiver E-mail Address

Caregiver Telephone: Home Cell Work | Caregiver Alternate Telephone: Home Cell Work | Okay to Leave a Message? Yes No

STEP 1 INSURANCE INFORMATION

Primary Prescription Insurance

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).

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United Therapeutics Remodulin (treprostinil) Referral Form

Patient Name: ______________________ **Date of Birth:** ______________________

STEP 2 PRESCRIBER INFORMATION

Prescriber Name - First ____ Last ____

NPI # ____ State License # ____

Office/Clinic/Institution Name ____

Address ____

City ____ State ____ Zip ____

Telephone ____ Fax ____

E-mail Address ____ Office Contact Name ____

Office Contact Phone ____ Office Contact E-mail ____

Preferred Method of Communication: Phone Email Mail Fax

STEP 2 MEDICAL INFORMATION / PATIENT EVALUATION / SUPPORTING DOCUMENTATION

Patient UT PAH Product Therapy Status for the requested drug:
Naïve/New Restart Transition

Current Specialty Pharmacy: Accredo CVS Specialty
Patient Status: Outpatient Inpatient
WHO Group: ________

NYHA Functional Class: I II III IV
Weight:_______ kg lb **Height:**___ft___in
Diabetic: Yes No

Allergies: Drug Allergies Non-Drug Allergies No Known Allergies

Diagnosis: The following ICD-10 codes do not suggest approval, coverage, or reimbursement for specific uses or indications.

I27.0 Primary pulmonary hypertension:
- Idiopathic PAH
- Heritable PAH

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

Other ICD-10: ______________________

Current Signed and Dated Documents Required for treprostinil therapy initiation:
- Right Heart Catheterization
- Echocardiogram
- History and Physical Including: Onset of Symptoms, PAH Clinical Signs and Symptoms, Need for Specific Drug Therapy, Course of Illness
- Treatment History (included on the next page)
- Transition Statement (if applicable)
- Calcium Channel Blocker Statement (included on the next page)

STEP 2 REMODULIN PRESCRIPTION INFORMATION

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:
Subcutaneous continuous infusion Intravenous continuous infusion

Dosing and Titration Instructions: To specify initial dosing and titration instructions, fill in the blanks **OR** use the lines below.

Initiation Dosage:_________ng/kg/min titrate _________ ng/kg/min every_________ days or at nearest cassette change until a goal dose of _________ng/kg/min is achieved.

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

____

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

For Remunity™ Pump System: Titration at cassette change or specify alternative/additional titration instructions below.

____

Dose changes requiring a new vial strength may be required to be on the next weekly shipment.

Central Venous Catheter Care:
Dressing change every ________ days Per IV standard of care

Check One (0.9% Sodium Chloride will be used if no box is checked):
- Remodulin Sterile Diluent for Injection
- pH 12 Sterile Diluent for Injection
- Epoprostenol Sterile Diluent for Injection
- 0.9% Sodium Chloride for Injection
- Sterile Water for Injection

Nursing Orders: RN visit to provide assessment and education on administration, dosing, and titration.
Location: Home Outpatient Clinic Hospital
Prescriber directed Specialty Pharmacy home healthcare RN visit(s) as detailed below:

____

Pumps:
CADD-MS® 3 Pumps (2) CADD-Legacy® Pumps (2)

Remunity™ Pump for Remodulin

Pharmacy Filled Starter Kit
(Remunity Pumps (2), Controllers, Batteries + Chargers)

Remunity Disposable Cassettes

Dispense prefilled Remunity cassettes containing prescribed concentration (filled by Specialty Pharmacy per USP 797 guidelines or equivalent), ancillary supplies, medical equipment necessary to administer medication. For patients on Remunity, cassettes are changed up to 48 hours or 72 hours. Any unused medication must be discarded. For initiation of Remodulin in the hospital and Remunity transition post discharge, collaboration from both SP and ordering prescriber are necessary.

Dispense 1 week of Remodulin (treprostinil) for emergency supply, and quantity sufficient of prescribed syringes, needles, and any other necessary supplies to fill cassette and administer for emergency supply.

Dispense teaching kits (syringes, needles, and any other necessary supplies to mix and assess patient's mixing skill). Quantity: Up to 4 kits per quarter and refill x1 year.

Dispense 1 month of needles, syringes, ancillary supplies, and medical equipment necessary to administer medication.

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

STEP 2 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: ______________________ ______________________ **Date:** __________
Dispense as Written **Substitution Allowed**

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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United Therapeutics Remodulin (treprostinil) Referral Form

Patient Name: ______________________ **Date of Birth:** ______________________

STEP 3 TREATMENT HISTORY AND TRANSITION STATEMENT

Please indicate Treatment History and list other concurrent medications.

Medication	Current	Discontinued
PDE-5 i (specify drugs)		
Epoprostenol		
Flolan® (epoprostenol sodium) for Injection		
Letairis® (ambrisentan) Tablets		
Remodulin® (treprostinil) Injection		
Tracleer® (bosentan) Tablets		
Tyvaso® (treprostinil) Inhalation Solution		
Veletri® (epoprostenol) for Injection		
Ventavis® (iloprost) Inhalation Solution		
Adempas® (riociguat) Tablets		
Opsumit® (macitentan) Tablets		
Orenitram® (treprostinil) Extended-Release		
Uptravi® (selexipag) Tablets		
Other		
Other		
Other		

Transition Statement

It is necessary for this patient (if applicable) to transition

FROM ______________ **TO** ______________

Please provide justification for this transition.

STEP 3 CALCIUM CHANNEL BLOCKER STATEMENT

Please indicate below if the Patient named above was trialed on a Calcium Channel Blocker prior to the initiation of therapy and indicate the results.

A Calcium Channel Blocker was not trialed because:

- Patient has depressed cardiac output
- Patient has systemic hypotension
- Patient has known hypersensitivity
- Patient is hemodynamically unstable or has a history of postural hypotension
- Patient did not meet ACCP Guidelines for Vasodilator Response
- Patient has documented bradycardia or second- or third-degree heart block
- Other: ______________________

OR

The following Calcium Channel Blocker was trialed:

____

With the following response(s):

- Patient hypersensitive or allergic ______________________
- Adverse event
- Pulmonary arterial pressure continued to rise
- Patient became hemodynamically unstable
- Disease continued to progress or patient remained symptomatic ______________________
- Other: ______________________

STEP 3 PRESCRIBER SIGNATURE

Prescriber Name: ______________________ **Prescriber Signature:** ______________________ **Date:** ______________

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

United Therapeutics Remodulin (treprostinil) Referral Form

Patient Name: ______________________ **Date of Birth:** ______________________

STEP 4 OPTIONAL SIDE EFFECT MANAGEMENT

Be sure to include directions to SPS for dosing in step 2 of this form. Remodulin is preferably infused subcutaneously but can be administered by a central venous line if the subcutaneous (SC) route is not tolerated because of severe site pain or reaction. In addition to the options listed below, patients can consider alternating SC site location (upper buttocks, back of arms, flanks, abdomen), trying alternative SC catheter (Cleo, Silhouette, Quick Set), as well as maintaining a 'good' site for several weeks.

*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 NSAIDs **(separate Rx may be required)** Gabapentin **(separate Rx required)**
Opioids **(separate Rx required)** Tramadol **(separate Rx required)** Other ______________________

Nausea/Vomiting:

Ondansetron **(separate Rx required)** Metoclopramide **(separate Rx required)** PPIs **(separate Rx may be required)**
Prochlorperazine **(separate Rx required)** Promethazine **(separate Rx required)** Other ______________________

Diarrhea:

Loperamide ________ mg ___ Frequency Diphenoxylate/atropine **(separate Rx required)** Dicyclomine **(separate Rx required)**
Probiotics Add fiber to diet Gluten free diet Other ______________________

SC Site Pain:

Non-pharmacologic considerations:

Hot or Cold compress Aloe Vera gel Arnica oil Dry catheter placement Other ______________________

Topical agents:

Topical corticosteroids - select from list (**separate Rx may be required**)
Hydrocortisone cream Triamcinolone acetonide cream Fluticasone propionate nasal spray Pimecrolimus cream

Other topical considerations:
Diphenhydramine HCL Hemorrhoid ointment PLO gel Lidoderm 5% patches Capsaicin 8% patch

Oral agents:

Antihistamines - select from list (**separate Rx may be required**)

H_1 blockers:
Cetirizine hydrochloride Fexofenadine hydrochloride

H_2 blockers:
Famotidine

Pain relievers - select from list (**separate Rx may be required**)
Acetaminophen Ibuprofen

Other considerations (**separate Rx may be required**)
Gabapentin Tramadol Amitriptyline HCl Pregabalin Opioids

Additional Instructions:

Provide any additional instructions for SPS on preferred communication or managing other side effects.

____
____
____
____
____
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____
____
____

Fax the completed referral form and documentation to the specialty pharmacy of your choice below.

STEP 5 FAX COVER SHEET

Date: ____________________

To: (check one)

Accredo
Fax: 1-800-711-3526
Phone: 1-866-344-4874

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

From: (Name of agent of prescriber who transmitted the facsimile/Prescription)

____

Facility Name: ____________________

Fax: ____________________

Included in this fax:

Completed Remodulin Therapy Referral Form including

- Step 1 - Patient Information/Insurance Information (Including front and back copies of insurance card)
- Step 2 - Prescriber/Prescription Information/Medical Information/Patient Evaluation
- Step 3 - Treatment History/Transition Statement and Calcium Channel Blocker Statement
- Step 4 - Optional Side Effect Management

Included signed and dated documents

- Right Heart Catheterization Results
- History and Physical (including Onset of Symptoms, PAH Clinical Signs and Symptoms, Course of Illness)
- Need for Specific Drug Therapy and 6-minute walk test results
- Echocardiogram Results

Number of Pages: ____________________

Additional Comments:

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