Yutrepia™ (treprostinil) inhalation powder

ENROLLMENT FORM

YUTREPIA™ (treprostinil) inhalation powder is available through select specialty pharmacy (SP) providers.

Complete all sections on this enrollment form. Let your patient know that the Specialty Pharmacy will be calling to process their prescription and that it is important to answer or return any messages.

Sign the Statement of Medical Necessity on page 2 for the Prescription.

Sign at the bottom of page 3 and pages 4-5 (for PAH patients) or page 6 (for PH-ILD patients).

Fax the enrollment form and signed supporting documents (using fax cover sheet provided on page 7) to your selected SP.

PATIENT INFORMATION

Patient Name (first, MI, last)

Date of Birth (mm/dd/yyyy)

Gender: ◯ Male ◯ Female

Address

Email

City | State | Zip

Phone ☐ Home ☐ Cell ☐ Work

Alternate Phone ☐ Home ☐ Cell ☐ Work

SHIPPING ADDRESS (if different from above):

Address

City | State | Zip

Preferred contact: ◯ Phone ◯ Email

Best time to call: ◯ Morning ◯ Afternoon ◯ Night

CAREGIVER

Caregiver Name

Caregiver Phone ☐ Home ☐ Cell ☐ Work

Alternate Phone ☐ Home ☐ Cell ☐ Work

Caregiver Email

Preferred contact: ◯ Phone ◯ Email

Best time to call: ◯ Morning ◯ Afternoon ◯ Night

INSURANCE INFORMATION

Pharmacy Benefits Manager

Please include copies of the front and back of all patient's medical and prescription insurance cards.

PRIMARY Medical Insurance Carrier

SECONDARY Medical Insurance Carrier

Policyholder Name

Policyholder Name

Policy ID Number | Group Number (if applicable)

Policy ID Number | Group Number (if applicable)

Medical Insurance Phone | Relationship to Policyholder

Medical Insurance Phone | Relationship to Policyholder

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Yutrepia™ (treprostinil) inhalation powder

ENROLLMENT FORM

Patient Name (first, MI, last) | Date of Birth

PRESCRIBER INFORMATION

Prescriber Name (first, MI, last) | NPI # | State License # | Tax ID #

Office / Clinic / Institution Name | Office Contact Name

Address | Office Contact Email

City | State | Zip | Phone | Fax

Preferred method of communication: ◯ Phone ◯ Email ◯ Fax

PRESCRIPTION INFORMATION

YUTREPIA™ (treprostinil) inhalation powder

Starting Dose: _____ mcg **Target Dose:** 159 mcg **OR** ◯ _____ mcg

Check off all NDC(s) to ensure SP is able to dispense labeled combinations needed to achieve prescribed dose.

NDC(s) Prescribed:

- ◯ 26.5 mcg (72964-011-01)
- ◯ 53 mcg (72964-012-01)
- ◯ 79.5 mcg (72964-013-01)
- ◯ 106 mcg (72964-014-01)

Quantity: 28-day supply **OR** ◯ _____ day supply

Refills: 12 refills **OR** ◯ _____ refills

Inhale: Two (2) breaths per capsule, four (4) times daily. Increase by 26.5 mcg, four (4) times daily, every week, as tolerated, to target maintenance dose.

OR

◯ Two (2) breaths per capsule, _____ times daily. Increase by _____ mcg, _____ times daily, every _____ ☐ week(s) / ☐ days, as tolerated, to target maintenance dose.

DOSE COMPARISON

Tyvaso® (Nebulized) QID Breaths	YUTREPIA™ QID Dose (mcg)	YUTREPIA™ Capsule Combination (mcg)
≤5	26.5	26.5
≥6 and ≤8	53	53
≥9 and ≤11	79.5	79.5
≥12 and ≤14	106	106
≥15 and ≤17	132.5	53 + 79.5
~18	159	79.5 + 79.5
~21	185.5	79.5 + 106
~24	212	106 + 106

SP will confirm the labeled combinations needed to achieve the prescribed dose

STATEMENT OF MEDICAL NECESSITY

PRESCRIBER SIGNATURE IS REQUIRED TO VALIDATE PRESCRIPTIONS.

I certify that the therapy ordered above is medically necessary and that I am personally supervising the care of this patient.

Prescriber Full Name (print)

Dispense As Written (DAW) / Brand Medically Necessary / No Substitution / May Not Substitute / Do Not Substitute

Substitution Permitted / May Substitute / Product Selection Permitted

SIGN HERE

Prescriber Signature* | Prescriber Signature* | Date

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution": _____

ATTN: New York and Iowa providers, please submit electronic prescription.

*Prescriber attests that this is his/her legal signature.

NO STAMPS. PRESCRIPTIONS MUST BE FAXED.

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 is not a guarantee of coverage or reimbursement.

Patient Name (first, MI, last)	Date of Birth	Prescriber Name (first, MI, last)	NPI #

NURSING ORDERS

NURSE VISITS (select **one** option)

- ☐ SP home healthcare RN visit(s) to provide assessment and education on self-administration of YUTREPIA™ to include dose, titration, and side effect management **OR**
- ☐ Prescriber-directed SP home healthcare RN visit(s) as detailed below:

Location:

- ☐ Home
- ☐ Outpatient clinic
- ☐ Hospital
- ☐ Virtual

***THE INFORMATION PROVIDED BELOW IS NOT A PRESCRIPTION. IF ADDITIONAL PRESCRIPTIONS ARE INTENDED, PROVIDE TO THE PATIENT SEPARATELY.**

SIDE EFFECT MANAGEMENT (OPTIONAL)

Headache:

- ☐ Acetaminophen _____ mg Frequency: _____
- ☐ Opioids *(separate Rx required)*
- ☐ Tramadol *(separate Rx required)*
- ☐ NSAIDs *(separate Rx may be 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)*
- ☐ Remind patient to hold the device level and swish and spit after each treatment session
- ☐ Other: _____

Throat Irritation:

- ☐ Lozenges *(not to be used during treatment session)*
- ☐ Oral phenol-based analgesic sprays
- ☐ Review medication administration technique
- ☐ Other: _____

Cough:

- ☐ Albuterol *(separate Rx required)*
- ☐ Benzonatate *(separate Rx required)*
- ☐ Cough Suppressant *(separate Rx may be required)*
- ☐ Oral phenol-based analgesic sprays
- ☐ Lozenges *(not to be used during treatment session)*
- ☐ Inhaled anticholinergics *(separate Rx required)*
- ☐ Inhaled steroids *(separate Rx required)*
- ☐ Other: _____

Additional Instructions:

PRESCRIBER SIGNATURE

SIGN HERE

Prescriber Signature	Prescriber Full Name (print)	Date

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Yutrepia™ (treprostinil) inhalation powder

ENROLLMENT FORM

COMPLETE THIS PAGE FOR
PAH PATIENTS ONLY

Patient Name (first, MI, last)	Date of Birth	Prescriber Name (first, MI, last)	NPI #

PATIENT EVALUATION

Patient Status:
- ◯ Outpatient
- ◯ Inpatient

YUTREPIA™ Status:
- ◯ Naïve / New
- ◯ Restart
- ◯ Transition

WHO Group: ☐

NYHA Functional Class:
◯ I ◯ II ◯ III ◯ IV

Diabetic?
- ◯ Yes
- ◯ No

Allergies:
- ◯ No known drug allergies (NKDA)
- ◯ Yes (specify): _____

Height:	Weight:	Date Taken:
☐ cm ☐ in	☐ kg ☐ lb	

Current Medications (list all):

TRANSITION STATEMENT

(if applicable)

It is necessary for this patient to transition

from:

to:

Please provide justification for this transition.

MEDICAL INFORMATION

REQUIRED: Please select one of the following ICD-10 codes, or Other ICD-10 code, as applicable. The following ICD-10 codes do not suggest approval, coverage, or reimbursement for specific uses or indications.

PAH

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

ICD-10 I27.2 Other secondary pulmonary hypertension
- ◯ Connective tissue disease
- ◯ Drugs/Toxins induced
- ◯ HIV
- ◯ Congenital heart disease
- ◯ Portal hypertension

◯ **Other ICD-10** Code: _____ Description: _____

TREATMENT HISTORY

Please indicate treatment history

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

PRESCRIBER SIGNATURE

SIGN HERE

Prescriber Signature	Prescriber Full Name (print)	Date

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 is not a guarantee of coverage or reimbursement.

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COMPLETE THIS PAGE FOR
PAH PATIENTS ONLY

Patient Name (first, MI, last)	Date of Birth	Prescriber Name (first, MI, last)	NPI #

CALCIUM CHANNEL BLOCKER STATEMENT

Indicate whether the patient named above was trialed on a calcium channel blocker prior to the initiation of therapy and provide the results.

A calcium channel blocker was not trialed because:

- ☐ Patient has depressed cardiac input
- ☐ Patient has systematic 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 brachycardia or second or third-degree heartblock
- ☐ Other: _____

The following calcium channel blocker was trialed:

The patient had the following response(s):

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

PRESCRIBER SIGNATURE

SIGN HERE

Prescriber Signature	Prescriber Full Name (print)	Date

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Yutrepia™ (treprostinil) inhalation powder

ENROLLMENT FORM

COMPLETE THIS PAGE FOR
PH-ILD PATIENTS ONLY

Patient Name (first, MI, last)	Date of Birth	Prescriber Name (first, MI, last)	NPI #

PATIENT EVALUATION

Patient Status:
- ◯ Outpatient
- ◯ Inpatient

YUTREPIA™ Status:
- ◯ Naïve / New
- ◯ Restart
- ◯ Transition

WHO Group: ☐

NYHA Functional Class:
◯ I ◯ II ◯ III ◯ IV

Diabetic?
- ◯ Yes
- ◯ No

Allergies:
- ◯ No known drug allergies (NKDA)
- ◯ Yes (specify): _____

Height:	Weight:	Date Taken:
☐ cm ☐ in	☐ kg ☐ lb	

Current Medications (list all):

TRANSITION STATEMENT

(if applicable)

It is necessary for this patient to transition

from:

to:

Please provide justification for this transition.

MEDICAL INFORMATION

REQUIRED: Please select one of the following ICD-10 codes, or Other ICD-10 code, as applicable. The following ICD-10 codes do not suggest approval, coverage, or reimbursement for specific uses or indications.

PH
- ◯ ICD-10 I27.23 Pulmonary hypertension due to lung diseases and hypoxia
- ◯ **Other ICD-10:** Code _____ Description _____

ILD

IIP:
- ◯ ICD-10 J84.10 Pulmonary fibrosis, unspecified
- ◯ ICD-10 J84.111 Idiopathic interstitial pneumonia, NOS
- ◯ ICD-10 J84.112 Idiopathic pulmonary fibrosis

CTD-related ILD:
- ◯ ICD-10 M34.81 Systemic sclerosis with lung involvement

Environmental/Occupational Lung Disease:
- ◯ ICD-10 J61 Pneumoconiosis due to asbestos and other mineral fibers
- ◯ ICD-10 J67.9 Hypersensitivity pneumonitis due to unspecified dust

Other causes:
- ◯ ICD-10 J17 Pneumonia in disease classified elsewhere

TREATMENT HISTORY

Please indicate treatment history

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

PRESCRIBER SIGNATURE

SIGN HERE

Prescriber Signature	Prescriber Full Name (print)	Date

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FAX

Using this cover sheet, fax all pages of the enrollment form, along with the requested clinical documentation, to the Specialty Pharmacy of your choice below.

Date

TO

☐ **Accredo Health Group, Inc.**

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 transmitting this fax/prescription)

Phone

Facility Name

Fax

RE

Patient Name

Date of Birth

DOCUMENTATION CHECKLIST

Indicate all current, signed and dated documents enclosed with this fax.

- ☐ Completed YUTREPIA Enrollment Form, including:
  - Patient/Insurance Information
  - Prescriber/Prescription Information
  - Medical Information/Patient Evaluation
- ☐ Copy of front and back of patient's insurance card(s)
- ☐ Right heart catheterization
- ☐ High-resolution CT scan *(not required for PAH patients)*
- ☐ Echocardiogram *(not required for PH-ILD patients)*
- ☐ 6-minute walk test results *(not required for PH-ILD patients)*
- ☐ History and physical, including onset of symptoms, clinical signs and symptoms and course of illness
- ☐ Need for specific drug therapy

Comments:

☐ **No of Pages** (including this cover sheet)