

- INSTRUCTIONS:**
- **Complete all relevant sections on page 1.** Inform your patient their SP will call to process their Rx.
 - **Complete the Standard Rx (pages 2 and 3) or the Voucher Rx (pages 3 and 4).** If only a Voucher Rx is submitted, a Standard Rx will be needed at a later date if you and your patient wish to continue therapy beyond the initial 28-day voucher period.
 - If needed, **complete the Voucher in-hospital URGENT start request (page 5).**
 - **Fax the form and signed supporting documents** to your selected SP (cover sheet provided).

PATIENT INFORMATION

Patient Name (first, MI, last)

Email

Home Cell Work

Home Cell Work

HOME ADDRESS

Phone

Alternate Phone

City

State Zip

Preferred contact: Phone Email

Best time to call: Morning Afternoon Night

Date of Birth (mm/dd/yyyy)

Gender: Male Female

Preferred language:

CAREGIVER Name

Caregiver Phone

Home Cell Work

Home Cell Work

Alternate Phone

Preferred contact: Phone Email

Best time to call: Morning Afternoon Night

Caregiver Email

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

INSURANCE INFORMATION

(Not required if only requesting a Voucher Prescription on page 4)

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

Patient Name (first, MI, last)

Date of Birth

Standard Prescription

STANDARD PRESCRIPTION INFORMATION

YUTREPIA™ (treprostinil) inhalation powder

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

Dispense:

 28-day supply, 1-year refills **OR** _____ day supply, _____ refills

Frequency:

 Two (2) breaths per capsule, four (4) times daily **OR**
 Two (2) breaths per capsule, _____ times daily

Titration (as tolerated, to target dose):

 Increase by 26.5 mcg every week, or as tolerated, **OR**
 Increase by _____ mcg, every _____ week(s) / _____ days

NDC(s) Prescribed

SP will dispense the prescribed dose per needed NDC combinations.

Included NDCs in this prescription:

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

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 NDC combinations needed to meet prescribed dose.

NURSING ORDERS

SP home health nurse visit(s) to teach and assess the self-administration of YUTREPIA, including dosing, titration, and side effect management.

 Decline Nursing Services

STATEMENT OF MEDICAL NECESSITY

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 EVALUATION
Patient Status:

- Outpatient
 Inpatient

Allergies:

- No known drug allergies (NKDA)
 Yes (specify):

YUTREPIA™ Status:

- Naïve / New
 Restart
 Transition

Current Medications (list all):
WHO Group:

- Group 1 (PAH)
 Group 3 (PH-ILD)
 Groups 1 and 3

TRANSITION STATEMENT
(if applicable)

It is necessary for this patient to transition

from:

to:

Please provide justification for this transition.

MEDICAL INFORMATION

Please select the relevant ICD-10 codes below or enter a different one if needed. Listed codes do not imply approval, coverage, or reimbursement for specific uses or indications.

PAH 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
 Drugs/Toxins induced Portal hypertension
 HIV

 Other

ICD-10: _____ Code _____ Description

 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

 Flolan® (epoprostenol sodium) for Injection Current Discontinued

 Letairis® (ambrisentan) Tablets Current Discontinued

 Opsumit® (macitentan) Tablets Current Discontinued

 Opsyvni® (macitentan/tadalafil) 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

 Upravi® (selexipag) Tablets Current Discontinued

 Veletri® (epoprostenol) for Injection Current Discontinued

 Winrevair™ (sotatercept-csrk) for Injection Current Discontinued

 Other: Current Discontinued

Voucher Prescription ▶ See full program requirements and conditions at www.Yutrepia.com/Voucher

The YUTREPIA Voucher Program provides a one-time, 28-day supply, of free product to eligible patients to help them determine whether YUTREPIA is the right choice for them. Using the Voucher Rx does not require ongoing use of YUTREPIA with a Standard Rx.

VOUCHER PRESCRIPTION INFORMATION

YUTREPIA™ (treprostinil) inhalation powder

Starting Dose: _____mcg **Target Dose:** 159 mcg **OR** _____mcg

Dispense: 28-day supply, 0 refills

Frequency: Two (2) breaths per capsule, four (4) times daily **OR**
 Two (2) breaths per capsule, _____ times daily

Titration: (as tolerated, to target dose) Increase by 26.5 mcg every week, or as tolerated, **OR**
 Increase by _____ mcg, every _____ week(s) / days

NDC(s) Prescribed

SP will dispense the prescribed dose per needed NDC combinations.

Included NDCs in this prescription:

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

NURSING ORDERS

SP home health nurse visit(s) to teach and assess the self-administration of YUTREPIA, including dosing, titration, and side effect management.

Decline Nursing Services

PRESCRIBER ATTESTATION

The undersigned, as treating physician, attests that:

- (i) I understand and agree that the sole purpose of this prescription (and the subsequent dispense of the medication) under Liquidia's Voucher Program is solely to clinically evaluate the medication's safety and tolerability in order to determine if it is the right treatment choice for the patient.
- (ii) I understand that patients are limited to one (1) free 28-day supply of YUTREPIA per lifetime under Liquidia's Voucher Program. Accordingly, I understand that should I and the patient determine that YUTREPIA is a good choice for the patient, I will need to write a new prescription of YUTREPIA for the patient in order to continue treatment.
- (iii) I shall not seek reimbursement for YUTREPIA or any Liquidia medication dispensed to the patient through Liquidia's Voucher Program from any government program or third-party insurer.
- (iv) I understand that any medication to be provided to this patient by Liquidia can only be provided directly to the patient or its authorized caregiver, is provided at no cost and may not be resold or billed to third-party payers, returned for credit or otherwise be placed in the stream of commerce.
- (v) All patient information supplied to Liquidia or its agents, contractors or subcontractors in connection with this enrollment form is accurate and has been obtained pursuant to an appropriate and valid patient authorization allowing for the release, transfer, and use of such information by Liquidia or its agents, contractors and sub-contractors in accordance with State and Federal law.
- (vi) I understand that Liquidia reserves the right to modify or terminate this program at any time as it deems fit, that Liquidia is under no obligation to continue the program and that any decision by Liquidia to modify or terminate this program will not give rise to any liability or obligation for Liquidia.

STATEMENT OF MEDICAL NECESSITY

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.

Voucher Prescription ► In-hospital URGENT start request

Please complete the following information.

HOSPITAL AND CONTACT INFORMATION

Hospital Name

Patient Room No.

Caregiver Name

Hospital Main Phone

Patient Hospital Room Phone

Caregiver Phone

SPECIALTY PHARMACY / DELIVERY INSTRUCTIONS

Select a Specialty Pharmacy (SP):

Accredo Health Group

Choose delivery method:

Courier – delivered to the patient in the hospital (available in certain areas)

Brown Bagging – delivered to the patient's home or alternate address for caregiver to bring to the hospital

White Bagging – delivered to the prescriber's office for prescriber or staff member to bring to the hospital

CVS Specialty

Choose delivery method:

CVS Pharmacy – delivered to a local CVS Retail Pharmacy for caregiver to pick up and bring to the hospital

CVS Nurse – SP nurse brings to the hospital during a scheduled nursing visit

Brown Bagging – delivered to the patient's home or alternate address for caregiver to bring to the hospital

White Bagging – delivered to the prescriber's office for prescriber or staff member to bring to the hospital

Please ensure that your patient or caregiver is available to answer the phone and respond to questions from the Specialty Pharmacy for the following interactions:

- To complete the voucher enrollment questions
- To speak with a pharmacist for the counseling call
- To speak with the Specialty Pharmacy nurse (if ordered) to schedule a visit

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.

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

*Only required if requesting a Standard Rx

Comments:

No of Pages (including this cover sheet)