Yutrepia™ (treprostinil) inhalation powder

VA REFERRAL FORM

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

PRESCRIBER:

- **Send the VA Pharmacy** the completed enrollment form and the fax cover sheet. The VA Pharmacy will forward these on to the SP.
- **Complete all sections on this form.** Let your patient know that the SP will be calling to process their prescription and that it is important to answer or return any messages.
- **Sign at the bottom** of pages 2 and 3

VA PHARMACY:

- **Review VA Pharmacy information** to ensure it's complete and correct.
- **Fax documents to the selected SP** using the fax cover sheet provided.

PATIENT INFORMATION

Patient Name (first, MI, last) | Date of Birth (mm/dd/yyyy) | Gender: ◯ Male ◯ Female

Address | Email

City | State | Zip | Phone | Ext | ☐ Home ☐ Cell ☐ Work | Preferred contact: ◯ Phone ◯ Email

SHIPPING ADDRESS (if different from above): | Alternate Phone | Ext | ☐ Home ☐ Cell ☐ Work | Best time to call: ◯ Morning ◯ Afternoon ◯ Night

Address

City | State | Zip

CAREGIVER

Caregiver Name | Caregiver Phone | Ext | ☐ Home ☐ Cell ☐ Work | Preferred contact: ◯ Phone ◯ Email

Caregiver Email | Alternate Phone | Ext | ☐ Home ☐ Cell ☐ Work | Best time to call: ◯ Morning ◯ Afternoon ◯ Night

VA PHARMACY INFORMATION

Name of VA Facility

Address

City | State | Zip

PAYMENT METHOD:
◯ Credit Card (call pharmacy contact)
◯ E-Invoice Tungsten Network

Purchase Order #

SHIP TO:
◯ Patient
◯ VA Pharmacy

	Phone	Ext	Fax	Email
Primary Purchasing Contact Name				
Primary Clinical Contact Name				
Secondary Purchasing Contact Name				
Secondary Clinical Contact Name				

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VA REFERRAL FORM

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

PRESCRIBER INFORMATION

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

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:** _____ 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": _____

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

NO STAMPS. PRESCRIPTIONS MUST BE FAXED.

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VA REFERRAL FORM

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:
- ◯ **1** (PAH patients)
- ◯ **3** (PH-ILD patients)

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

Diabetic?
◯ Yes ◯ No

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

Height: ☐ cm ☐ in

Weight: ☐ kg ☐ lb

Date Taken:

Current Medications (list all):

OPT-IN NURSING VISITS

Nurse-supported patient education is available at no cost to patients who are learning to administer their YUTREPIA™ therapy.

If you would like your patient to receive this support, please select **one** of the options below.

- ◯ 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

Note: Order for this drug is not inclusive of skilled nursing home health services. To request skilled nursing services for home inhalation therapy, the referring VA provider should enter a COMMUNITY CARE-GEC SKILLED HOME CARE consult. The VA facility community care office will coordinate the requested service through CCN (Community Care Network) or VCA (Veteran Care Agreement) as appropriate.

PRESCRIBER SIGNATURE

SIGN HERE

Prescriber Signature	Prescriber Full Name (print)	Date

 US-YUTR-2400013 (05-2025)

Liquidia™

Yutrepia™ (treprostinil) inhalation powder

FAX

Instructions for VA Pharmacy:
Using this cover sheet, fax all pages of the enrollment form 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 VA pharmacy contact transmitting this fax/prescription) | Phone | Ext

Facility Name | Fax

RE

Patient Name | Date of Birth

Comments:

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