Accredo Health Group Inc. Phone Number: 866-344-4874 **UEI: LERPSGUE3528**

VELETRI® (epoprostenol) for Injection Enrollment and Prescription Form

FOR VA PATIENTS ONLY

1. Forward this completed form to the VA Pharmacy.

2. The VA Pharmacy will fax completed form to Accredo Health Group Inc. at 800-711-3526.

Johnson & Johnson Health Care Systems Inc., our affiliates, our service providers, the Veterans Health Administration, your specialty pharmacy or pharmacies, and your health plans will use the information you provide to fill your prescription and to provide other services you may select.

Referral date: _____ ☐ **New patient** ☐ **Current**

Diagnosis

Please select the diagnosis information that most accurately and completely describes the signs, symptoms, and condition of the patient:

☐ **ICD-10 127.0 Primary Pulmonary Hypertension**
- ☐ Idiopathic PAH ☐ Heritable PAH
- Date of Onset _____

☐ **ICD-10 127.21 Secondary Pulmonary Arterial Hypertension**
- ☐ Connective tissue disease ☐ Congenital heart disease with repaired shunts
- ☐ Drugs/toxins induced ☐ Other _____
- Date of Onset _____

New York Heart Association (NYHA) Functional Classification ☐ III ☐ IV

Prescription

VELETRI®—continuous IV infusion administered via ambulatory pump

Dosing weight: _____ ☐ lbs ☐ kg Height: _____ ☐ in ☐ cm

☐ NKDA ☐ Known drug allergies: _____

Diabetic: ☐ Yes ☐ No Initial dose: _____ ng per kg per min

Titrate by _____ ng per kg per min every _____ days until goal of _____ ng per kg per min is reached.

Discharge dose: _____ ng per kg per min Concentration: _____ ng/mL

Dispense two (2) ambulatory infusion pumps appropriate for VELETRI® if the patient does not currently have appropriate ambulatory infusion pumps.

Refills: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11

Ship-to directions:

☐ Patient's home ☐ VA Pharmacy

Address (no PO Box):

City:

State: ZIP:

Ship Attn:

Patients should keep at least a 7-day backup supply of medicine and supplies at all times.

Quantity: Dispense 1 month of drug and supplies, including pump(s)

Choose one: ☐ Sterile water for injection ☐ Sodium chloride 0.9% injection

The medicine cost does not include the ambulatory pumps and supplies. Those are provided at an additional charge.

Nurse Support*

☐ Please check this box if you would like your patient to receive nurse-supported* patient education on VELETRI® mixing (reconstitution), administration, and management. Johnson & Johnson-sponsored nurse support* is available to patients who are learning to self-mix their VELETRI® therapy.

*Johnson & Johnson-sponsored nurse support is limited to education for patients about their therapy by J&J, its administration, and/or their disease. It is intended to supplement a patient's understanding of their therapy, and is not intended to provide medical advice, replace a treatment plan from the patient's doctor or nurse, directly provide case management services, or serve as a reason to prescribe. Program rules and limitations will apply.

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

I have made the determination, based on my independent clinical judgment, that the medicine ordered is medically necessary for the patient for the intended use. I am personally supervising the care of this patient. I authorize Johnson & Johnson Health Care Systems Inc., its affiliates, agents, and contractors to act on my behalf for the limited purposes of transmitting this prescription to the appropriate pharmacy designated by the patient utilizing their benefit plan. I certify that the patient has authorized me to share their information on this form. **PHYSICIAN SIGNATURE REQUIRED TO VALIDATE PRESCRIPTIONS. Physician attests this is his/her legal signature (NO STAMPS). Prescriptions must be faxed.**

Prescriber's Signature: _____

Prescriber's printed name: _____ **Date:** _____

(Physician attests this is his/her legal signature. **NO STAMPS.**)

This prescription is valid only if transmitted by means of a facsimile machine.

Choose one: ☐ Urgent: Patient in hospital ☐ Emergent: Admission after 48-72 hours ☐ Standard: Admission within 4+ days

Start-of-care date (REQUIRED): _____ **Tentative discharge date:** _____

All fields must be completed to expedite prescription fulfillment.

Physician information

Name:			NPI #:
Name of facility:	MD specialty:		
Contact name and phone #:	State license #:		Phone #:
Address:			Suite:
City:	State:	ZIP:	Fax #:
PCP (if applicable/different from prescribing MD):			Phone #:

Patient information

Name:			DOB:
Address:	City:	State:	ZIP:
Preferred language, if not English:	Phone #:		Sex at Birth: ☐ Male ☐ Female
Parent/guardian (if applicable):			Alternate phone #:

VA Pharmacy information

Name of facility:				
Address:	Suite:	City:	State:	ZIP:
Payment Method: ☐ Credit Card (call pharmacy contact) ☐ E-Invoice Tungsten Network		**Purchase Order #:** _____		
Primary purchasing contact name:	Phone #:	Fax #:	Email:	
Primary clinical contact name:	Phone #:	Fax #:	Email:	
Secondary purchasing contact name:	Phone #:	Fax #:	Email:	
Secondary clinical contact name:	Phone #:	Fax #:	Email:	

Please read full Prescribing Information for VELETRI®.

Print Form