Access Solutions and Support Team (ASSIST)
Request for Support Form

Please return this application to ASSIST by fax 1-800-380-5294 or mail to:
ASSIST, 1130 S. Harbor City Blvd., Suite 103, Melbourne, FL 32901. Please include all required signatures.
For questions: Call ASSIST at 1-877-864-8437 or visit utassist.com.

We work in 3 ways to connect you to the United Therapeutics medicine prescribed to you. Please select the support you are requesting below (you may select more than one):

☐ **Benefit Verification:** We can verify your insurance coverage and notify you of your out-of-pocket costs.
☐ **Access to Therapy:** We can coordinate with your insurance plan, physician, and specialty pharmacy to get your medication to you.
☐ **Financial Assistance:** We can provide information about available financial assistance options.

Therapy: ☐ **Adcirca** ☐ **Orenitram** ☐ **Remodulin** ☐ **Tyvaso** ☐ **Tyvaso DPI**

STEP 1 PATIENT INFORMATION

Name: First _____ Middle _____ Last _____

Date of Birth _____ Gender _____ SSN _____

Home Address _____ Do you reside in the United States? ☐ Yes ☐ No

City _____ State _____ Zip _____

Telephone ☐ Home ☐ Cell ☐ Work _____ Alternate Telephone ☐ Home ☐ Cell ☐ Work _____ Best Time to Call ☐ Morning ☐ Afternoon ☐ Evening

E-mail Address _____

Caregiver/Family Member _____ Caregiver Telephone ☐ Home ☐ Cell ☐ Work _____ Caregiver Alternate Telephone ☐ Home ☐ Cell ☐ Work _____

STEP 1 ASSIST PATIENT AUTHORIZATION

By signing below, I authorize my health care providers, including the pharmacies I use, and my health insurance plan(s) to disclose my personal health information, including information about my insurance, prescriptions, and medical condition ("My Information") to United Therapeutics and its contractors and business partners, including the Access Solutions and Support Team (ASSIST) (collectively "United Therapeutics"), for the following purposes:

1. Support services (and related information and materials) related to any of United Therapeutics' products, including but not limited to, online support, financial assistance services, compliance and persistency, and other therapy support services
2. Conduct data analytics, market research, and other internal business activities
3. Information about United Therapeutics' products, services and programs, and other topics of interest for marketing, educational, or other purposes

I understand that my health care providers (including specialty pharmacies) may receive remuneration from UT in exchange for disclosing my information and/or using my information to contact me with communications about UT products and other patient support services.
I understand that federal privacy laws may not regulate the use and disclosure of My Information once it is disclosed pursuant to this authorization, and I authorize United Therapeutics to use and disclose My Information for the purposes specified above. I understand that my health care treatment and health insurance eligibility and coverage will not be affected if I refuse to sign this authorization, but that if I do not sign, I may not be eligible to receive education and patient support services provided by United Therapeutics. This authorization will expire in ten (10) years after the date it is signed, unless a shorter period is mandated by state law or if I revoke the authorization earlier, which I understand I may do by sending a notice of revocation to United Therapeutics by mail (sent to ASSIST, 1130 S. Harbor City Blvd., Suite 103, Melbourne, Florida 32901), or by fax (sent to 1-800-380-5294). If I do revoke the authorization, I understand the revocation will apply only to uses and disclosures of My Information after the date my notice of revocation is received by United Therapeutics and not to any uses or disclosures made prior to that date. I understand that I am entitled to receive a copy of this authorization once signed.

SIGN HERE

Patient Name (Print) _____

Patient Signature _____ Date _____

Patient's representative must sign here. Patient Representative Signature _____ Date _____

Describe relationship to patient and authority to sign this form for patient: _____

STEP 2 PRESCRIBER INFORMATION

Name: First _____ Last _____ NPI # _____

Facility Name _____ Group NPI # (if applicable) _____

Address _____ City _____ State _____ Zip _____

Office Contact Name _____ Telephone _____ Fax _____

E-mail Address _____ Preferred Method of Communication ☐ Phone ☐ Email ☐ Mail ☐ Fax

STEP 2 PRESCRIBER AUTHORIZATION AND SIGNATURE

SIGN HERE

I understand that an application does not guarantee my patient being eligible to receive any programs coordinated and ordered by ASSIST. I understand and acknowledge that if my patient's financial or insurance status changes, the patient may no longer be eligible for certain programs coordinated and ordered by ASSIST. I understand I am under no obligation to prescribe any United Therapeutics Corporation product and can discontinue the utilization of its programs at any time.

Physician: _____ **Physician's Signature:** _____ **Date:** _____

FAX COVER SHEET

Date:

To: assist Access Solutions and Support Team UNITED THERAPEUTICS

Fax Number 1-800-380-5294
Phone Number 1-877-864-8437

From:

Facility Name:

Fax:

Included in this fax:

☐ **Completed and signed ASSIST Request for Support Application Form**

- ☐ STEP 1 - Patient Information and ASSIST Patient Authorization
- ☐ STEP 2 - Prescriber Information and Prescriber Authorization and Signature

Number of Pages:

Comments:

Patient documents may be mailed to: ASSIST, 1130 S. Harbor City Blvd., Suite 103, Melbourne, FL 32901. US-ASSIST-0156