

Actelion®'s Epoprostenol for Injection - RTS (Room Temperature Stable) PRESCRIPTION & ENROLLMENT FORM

Referral date: _____ New patient
 Current

1 PATIENT INFORMATION

Patient name _____
Date of birth _____ Male Female SSN _____
Street address _____ Apt # _____
City _____ State _____ Zip _____
Parent/Guardian (if applicable) _____
Phone _____ Employer _____

May we contact the patient regarding insurance benefits and product delivery? No Yes

Primary insurance company

Insurance company phone # _____
Insured name _____ Date of birth _____
SSN _____ Relationship to patient _____
Insured employer _____ Group # _____
Identification # _____

Drug card company

Drug card company phone # _____
RxBIN # _____ PCN # _____ Person code _____
Policy # _____ Group # _____

Secondary insurance company

Insurance company phone # _____
Insured name _____ Date of birth _____
SSN _____ Relationship to patient _____
Insured employer _____ Group # _____
Identification # _____

Please attach front and back copy of patient's insurance cards, if available.

2 PRESCRIBER INFORMATION

All fields must be completed to expedite prescription fulfillment.

Prescriber name and title _____
Practice specialty _____
Office contact _____
Street address _____ Suite # _____
City _____ State _____ Zip _____
Phone _____ Fax _____
NPI # _____ License # _____
DEA # _____ UPIN # _____
Referral source: (check one) Prescribing physician Patient self-referral No referring MD
PCP (if applicable/different from prescribing MD) _____ Phone _____
Date _____ Time _____
Name and title of person faxing this form _____

3 CLINICAL INFORMATION

To support the diagnosis, include a history and a physical in addition to RIGHT heart cath with PA pressures, echocardiogram, perfusion scan, and trialed use of calcium channel blockers.

Diagnosis

ICD 416.0 - Pulmonary Arterial Hypertension (PAH) ICD 416.8 - Pulmonary Arterial Hypertension
 Idiopathic PAH Familial PAH Congenital heart disease HIV
 Connective tissue disease
 Other _____

Weight _____ lbs kg Height _____ inches cm Diabetic: No Yes
 NKDA Known drug allergies _____

Prescription information

Actelion's Epoprostenol for Injection - RTS (Room Temperature Stable)
(continuous IV infusion administered via ambulatory pump)

Initial dose: _____ ng per kg per min Dosing weight _____ kg
Titrate by _____ ng per kg per min every _____ days until goal of _____ ng per kg per min is reached.
Final concentration is _____ ng per mL.

Quantity: Dispense 1 month of drug and supplies, including pump(s)
____ Refills Choose one: Sterile water for injection Sodium chloride 0.9% injection
Select one: Urgent - Patient in hospital Emergent - Admission within 48-72 hours
 Standard - Admission after 4 days or more

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

Home nursing request to be provided by Accredo nursing staff (Check all that apply):

In-hospital training (Accredo) Post discharge visit/in-home follow-up
 Home assessment/training prior to initiation of therapy
 Dispense teaching kits DECLINE: All referenced nursing

If nursing services will be required for therapy administration, the home health nurse will call for additional orders per state regulations.

Discharge planner/coordinator name _____
Date _____ Time _____
Fax # _____ Office/page phone # _____

By signing below, I certify that the above therapy is medically necessary.

Prescriber's printed name _____

Prescriber's signature (sign below) _____ Date _____

Dispense as written

Substitution allowed

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