Pulmonary arterial hypertension (PAH)

PRESCRIPTION & ENROLLMENT FORM Page 1 of 2

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? ❑ **Yes** ❑ **No**
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 copy of front and back 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 # ____________
UPIN # ____________
Referral source (check one) ❑ Prescribing physician ❑ Patient self-referral ❑ No referring MD
❑ Referring MD (if different from prescribing MD) ____________
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, and trialed use of calcium channel blockers.

Diagnosis

ICD 416.0–Pulmonary arterial hypertension (PAH)
❑ Idiopathic ❑ PAH Familial

ICD 416.8–Pulmonary arterial hypertension
❑ Connective tissue disease ❑ HIV
❑ PAH Congenital heart disease
❑ Other ____________

Weight ____________ ❑ lbs ❑ kg Height ____________ ❑ inches ❑ cm Diabetic ❑ Yes ❑ No
❑ NKDA ❑ Known drug allergies ____________

To reach your team, call toll-free **1 866 FIGHT-PH | 1 866 344-4874.**
Please fax both pages of the completed form to the PAH team at 1 800 711-3526.

Pulmonary arterial hypertension (PAH)

PRESCRIPTION & ENROLLMENT FORM

4 MEDICATION ORDERS

Patient name ______________________ DOB __________

❑ ***Revatio***® 20-mg tablet (Sig: take 1 tablet po tid, or other ______________)
Dispense tablets as ❑ 30-day supply ❑ 90-day supply ❑ Other ______________

❑ ***Adcirca***® 20-mg tablet (Sig: take 2 tablets daily, or other ______________)
Dispense tablets as ❑ 30-day supply ❑ 90-day supply ❑ Other ______________

Refill information for *Revatio* or *Adcirca*
(check one) ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10 ❑ 11

Tyvaso® (treprostinil) Inhalation Solution

Target dose: 9 breaths (54 mcg) QID — Start with 3 breaths (18 mcg) QID (if 3 breaths are not tolerated, use 1 to 2 breaths). Increase by 3 breaths at 1- to 2-week intervals, if tolerated, until the target dose of 9 breaths (54 mcg) QID.

Quantity: ❑ *Tyvaso* Inhalation System Starter Kit (28-day supply)
❑ *Tyvaso* Inhalation System Refill Kit (28-day supply) X ________ refills

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 *Tyvaso*
❑ 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 ______________

The following prostacyclin therapies require additional information (e.g., diluent or titration). Please be sure to complete all information.

❑ ***Flolan***® (continuous IV infusion administered via ambulatory pump)
❑ **Epoprostenol** (continuous IV infusion administered via ambulatory pump)
❑ ***Veletri***® (continuous IV infusion administered via ambulatory pump)
Diluents (choose one) ❑ Sterile Water for Injection ❑ 0.9% Sodium Chloride Injection

❑ ***Remodulin*® *SubQ*** (continuous subcutaneous infusion administered via ambulatory pump)
❑ ***Remodulin*® *IV*** (continuous IV infusion administered via ambulatory pump)
Diluents (choose one) ❑ 0.9% Sodium Chloride Injection ❑ *Flolan* diluent ❑ Epoprostenol diluent
❑ Sterile Water for Injection

Dose information
Initial dose __________ ng per kg per min Dosing weight __________ kg
Titrate by __________ ng per kg per min every __________ days as tolerated until __________ ng per kg per min is reached.

Refill information
(check one) ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10 ❑ 11

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 *Flolan*, *Remodulin*, *Tyvaso*, *Veletri*, or Epoprostenol 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 ______________________

Date __________

Prescriber's signature (sign below)

Dispense as written ______________________

Substitution allowed ______________________

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

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