PAH oral PRESCRIPTION & ENROLLMENT FORM

accredo® Specialty Pharmacy

Four simple steps to submit your referral.

1 PATIENT INFORMATION

☐ New patient ■ Current

Patient's name FirstName Last1478851499401
Date of birth 2001-03-03 ■ Male ☐ Female Last 4 digits of SSN _____
Street address address1478851504693 Apt # _____
City city1478851504901 State MA Zip 14788
Parent/guardian (if applicable) _____
Home phone 478-851-5058 Work phone _____ Cell phone _____
Evening phone _____ E-mail address FirstNameLast1478851499401@zapprx.com
Patient's primary language: ☑ English ❑ Other If other, please specify _____

Please attach front and back of patient's insurance cards or complete information below.

Insurance company Blue Cross Blue Shield Phone 111-111-1111
Insured's name FirstName Last1478851499401
Insured's employer Policy Holder Employer Name Relationship to patient SELF
Identification # 21931 Policy/group # FLBCS
Prescription card: ☑ Yes ❑ No If yes, carrier Pharmacy Benefits
Policy # _____ Group # _____ Is patient eligible for Medicare? ☐ Yes ☐ No
Does patient have a secondary insurance? ☐ Yes ■ No

2 PRESCRIBER INFORMATION

All fields must be completed to expedite prescription fulfillment.

Date 2016-12-08 Time 07:39:43 UTC Date medication needed _____
Prescriber's name and title Lindsay Goldman
If NP or PA, under direction of Dr. _____ Office contact _____
Clinic/hospital affiliation _____ Street address 192 South St Suite # _____
City Boston State MA Zip 02111
Phone 617-555-5555 Fax _____
NPI # 6895439888 License # 666-7654-999
Deliver product to: ❑ Office ☑ Patient's home ❑ Clinic
Clinic location _____

3 CLINICAL INFORMATION

Primary ICD-10 code: K76.6 Portal Hypertension
Diagnosis

ICD I27.0 - Pulmonary arterial hypertension (PAH)
❑ Idiopathic PAH ❑ Familial PAH

ICD I27.2 - Pulmonary arterial hypertension
❑ Congenital heart disease ❑ Connective tissue disease
❑ HIV ■ Other 572.3 Portal Hypertension

Weight 57 ❑ lbs ■ kg Height 22 ■ inches ❑ cm Diabetic: ■ No ☐ Yes
❑ NKDA ■ Known drug allergies Iodine

Concurrent meds _____

Please fax completed form to the PAH team at 800.711.3526.
To reach your PAH team, call toll-free 866.344.4874.

PAH-00150-070115 amc1806

4 PRESCRIBING INFORMATION

Medication	Strength / Formulation	Directions	Quantity/Refills
■ Adcirca® (tadalafil)	20 mg tablet	Take 2 tablets po DAILY ❑ Other _____	Dispense: ❑ 1-month supply ❑ 3-month supply ■ Other **0days supply** Refills 11
❑ Revatio® (sildenafil)	20 mg tablet	Take 1 tablet po TID ❑ Other _____	Dispense: ❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____

If shipped to physician's office, physician accepts on behalf of patient for administration in office.

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

I authorize HUB 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.

Prescriber's signature (sign below) (Physician attests this is his/her legal signature. **NO STAMPS**)

PHYSICIAN SIGNATURE RI

_____ _____ 12/08/2016 _____
Date Dispense as written Date Substitution allowed

The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

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