Pulmonary arterial hypertension (PAH)

PRESCRIPTION & ENROLLMENT FORM

Referral date _____ ☐ New patient ☑ Current

1 PATIENT INFORMATION

Patient name FirstName Last1478851499401

Date of birth 2001-03-03 ☑ Male ☐ Female SSN _____

Street address address1478851504693 Apt # _____

City city1478851504901 State MA Zip 14788

Parent/guardian (if applicable) _____

Phone 478-851-5058 Employer Policy Holder Employer Name

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

Primary insurance company Blue Cross Blue Shield

Insurance company phone 111-111-1111

Insured name FirstName Last1478851499401 Date of birth 2001-03-03

SSN _____ Relationship to patient SELF

Insured employer Policy Holder Employer Name Group # FLBCS

Identification # 21931

Drug card company Pharmacy Benefits

Drug card company phone _____

RxBIN # 3858.0 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 Lindsay Goldman

Practice specialty PAH

Office contact _____

Street address 192 South St Suite # _____

City Boston State MA Zip 02111

Phone 617-555-5555 Fax _____

NPI # 6895439888 License # 666-7654-999

UPIN # _____

Referral source (check one) ☐ Prescribing physician ☐ Patient self-referral ☑ No referring MD

☐ Referring MD (if different from prescribing MD) _____

Date 2016-11-30 Time 14:09:41 UTC

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) **ICD 416.8**–Pulmonary arterial hypertension

☐ Idiopathic ☐ PAH Familial ☐ Connective tissue disease ☐ HIV

☐ PAH Congenital heart disease

☑ Other 572.3 Portal Hypertension

Weight 57 KG ☐ lbs ☑ kg Height 22 IN ☑ inches ☐ cm Diabetic ☐ Yes ☑ No

☐ NKDA ☑ Known drug allergies Iodine

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)

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4 MEDICATION ORDERS

Patient name FirstName Last1478851499401 DOB 2001-03-03

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/kg/min___ ng per kg per min Dosing weight 57.0 kg
Titrate by ___ng/kg/min___ ng per kg per min every ___days___ days as tolerated until ___ng/kg/min___ 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 printed name Lindsay Goldman

Date 11/30/2016

Prescriber signature (sign below)

Dispense as written _____

Substitution allowed

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

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

accredo®

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.

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