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 Last1484643319438
Date of birth 1945-09-03 ☒ Male ☐ Female Last 4 digits of SSN _____
Street address address1484643323988 Apt # _____
City city1484643324124 State MA Zip 14846
Parent/guardian (if applicable) _____
Home phone 484-643-3247 Work phone _____ Cell phone _____
Evening phone _____ E-mail address FirstNameLast1484643319438@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 Last1484643319438
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 2017-01-17 Time 09:06:52 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 989-765-5675
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 51 ☐ lbs ☒ kg Height 43 ☒ 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.

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 _____ Refills _____
☒ Revatio® (sildenafil)	20 mg tablet	Take 1 tablet po TID ☒ Other Take 1 tablet orally 3 times per day.	Dispense: ☐ 1-month supply ☐ 3-month supply ☒ Other **0days supply** Refills **11**

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

_____ _____ 01/17/2017 _____
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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