

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) **ICD 416.8**—Pulmonary arterial hypertension

Idiopathic PAH Familial 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**.

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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 _____

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

Prescriber printed name _____

Date _____

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

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

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 _____

Prescriber signature (sign below)

Dispense as written _____

Substitution allowed

accredo®

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