

# Prescription & Enrollment Form Pulmonary arterial hypertension (PAH)



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Honolulu, HI 96813-5412

Four simple steps to submit your referral.

## 1 PATIENT INFORMATION

New patient  Current patient

Patient's first name \_\_\_\_\_  
 Last name \_\_\_\_\_ Middle initial \_\_\_\_\_  
 Date of birth \_\_\_\_\_  Male  Female Last 4 digits of SSN \_\_\_\_\_  
 Street address \_\_\_\_\_ Apt # \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Parent/guardian (if applicable) \_\_\_\_\_  
 Cell phone \_\_\_\_\_ Other phone \_\_\_\_\_  
 E-mail address \_\_\_\_\_  
 Patient's primary language:  English  Other If other, please specify \_\_\_\_\_

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

Insurance company \_\_\_\_\_ Phone \_\_\_\_\_  
 Insured's name \_\_\_\_\_  
 Insured's employer \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
 Identification # \_\_\_\_\_ Policy/group # \_\_\_\_\_  
 Prescription card:  Yes  No If yes, carrier \_\_\_\_\_  
 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 \_\_\_\_\_ Time \_\_\_\_\_ Date medication needed \_\_\_\_\_  
 Prescriber's first name \_\_\_\_\_ Last name \_\_\_\_\_  
 Prescriber's title \_\_\_\_\_  
 If NP or PA, under direction of Dr. \_\_\_\_\_  
 Office contact and title \_\_\_\_\_  
 Office contact e-mail \_\_\_\_\_  
 Office/clinic/institution name \_\_\_\_\_  
 Clinic/hospital affiliation \_\_\_\_\_  
 Street address \_\_\_\_\_ Suite # \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone \_\_\_\_\_ Fax \_\_\_\_\_  
 NPI # \_\_\_\_\_ License # \_\_\_\_\_  
 Deliver product to:  Office  Patient's home  Clinic  
 Clinic location \_\_\_\_\_

## 3 CLINICAL INFORMATION

Primary ICD-10 code: \_\_\_\_\_

### Diagnosis

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

ICD I27.21 - Pulmonary arterial hypertension  Congenital heart disease

Connective tissue disease  HIV  Other \_\_\_\_\_

Concurrent meds \_\_\_\_\_

Weight \_\_\_\_\_ kg/lbs Height \_\_\_\_\_ cm/in Date recorded \_\_\_\_\_

Diabetic:  Yes  No  NKDA  Known drug allergies \_\_\_\_\_

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 \_\_\_\_\_

Discharge planner/coordinator name \_\_\_\_\_

## 4 PRESCRIBING INFORMATION

Medication	Strength/Formulation	Directions	Quantity/Refills
<input type="checkbox"/> ambrisentan	<input type="checkbox"/> 5 mg tablet <input type="checkbox"/> 10 mg tablet	<input type="checkbox"/> Take one tablet by mouth once daily <input type="checkbox"/> Other _____	Dispense: <input type="checkbox"/> 1-month supply <input type="checkbox"/> 3-month supply <input type="checkbox"/> Other _____ Refills _____
<input type="checkbox"/> bosentan	<input type="checkbox"/> 62.5 mg tablet <input type="checkbox"/> 125 mg tablet	<input type="checkbox"/> Take 62.5 mg by mouth twice daily x 4 weeks, then increase to maintenance dose of 125 mg twice daily <input type="checkbox"/> Other _____	Dispense: <input type="checkbox"/> 1-month supply Refills _____
<input type="checkbox"/> bosentan	32 mg tablet (available only as Tracleer)	Directions _____ _____ _____ _____	Dispense: <input type="checkbox"/> 28-day supply Refills _____
<input type="checkbox"/> sildenafil	20 mg tablet	<input type="checkbox"/> Take one tablet by mouth three times a day. <input type="checkbox"/> Other _____	Dispense: <input type="checkbox"/> 1-month supply <input type="checkbox"/> 3-month supply <input type="checkbox"/> Other _____ Refills _____
<input type="checkbox"/> sildenafil oral suspension	10 mg/mL 112 mL	<input type="checkbox"/> Take 1 mL (10 mg) three times a day <input type="checkbox"/> Other _____	Dispense: <input type="checkbox"/> 1-month supply <input type="checkbox"/> 3-month supply <input type="checkbox"/> Other _____ Refills _____
<input type="checkbox"/> tadalafil	20 mg tablet	<input type="checkbox"/> Take two tablets by mouth daily. <input type="checkbox"/> Other _____	Dispense: <input type="checkbox"/> 1-month supply <input type="checkbox"/> 3-month supply <input type="checkbox"/> Other _____ Refills _____
<input type="checkbox"/> Tyvaso® (treprostinil)	2.9 mL amp administered via inhaler device	<input type="checkbox"/> Use 1 ampule per day. Inhale 3–9 breaths as tolerated four times daily. <input type="checkbox"/> Other _____	Dispense: <input type="checkbox"/> Starter kit x 1 month, 0 refills <input type="checkbox"/> Refill kit: <input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> Other _____ Refills _____

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

Medication	Pump and diluent	Dose and directions	Quantity/Refills
<input type="checkbox"/> epoprostenol	CADD Legacy <input type="checkbox"/> epoprostenol sterile diluent for injection	Continuous IV infusion administered via ambulatory pump. Initial dose _____ ng per kg per min. Dosing weight _____ kg. Titrate by _____ ng per kg per min every _____ days until _____ ng per kg per min is reached. Final concentration is _____ ng per mL.	Dispense: <input type="checkbox"/> 1-month supply <input type="checkbox"/> 3-month supply <input type="checkbox"/> Other _____ Refills _____
<input type="checkbox"/> Veletri®	CADD Legacy <input type="checkbox"/> 0.9% sodium chloride <input type="checkbox"/> sterile water for injections		
<input type="checkbox"/> treprostinil IV	CADD Legacy <input type="checkbox"/> treprostinil sterile diluent for injection <input type="checkbox"/> 0.9% sodium chloride <input type="checkbox"/> epoprostenol sterile diluent for injection <input type="checkbox"/> sterile water for injection		
<input type="checkbox"/> treprostinil IV	CADD MS3 <input type="checkbox"/> 0.9% sodium chloride <input type="checkbox"/> sterile water for injections		
<input type="checkbox"/> Remodulin® SubQ	CADD MS3		
<input type="checkbox"/> Other instructions _____			

You must note the name of the brand product if brand is medically necessary for your patient \_\_\_\_\_

Prescriber, please check here to authorize ancillary supplies such as needles, syringes, sterile water, infusion device, nebulizer, etc. to administer the therapy as needed for administration. Send quantity sufficient for medication days supply

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  Dispense teaching kits

Home assessment/training prior to initiation of Flolan/treprostinil/Tyvaso therapy  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.

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 also authorize Accredo to initiate any de minimus authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans, to the extent not prohibited. Prescriber's signature (sign below) (Physician attests this is his/her legal signature. **NO STAMPS**) **PHYSICIAN SIGNATURE REQUIRED**

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, substitution prevention, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

Please fax completed form to the PAH team at 808.650.6487. To reach your PAH team, call toll-free 808.650.6488.

You can now monitor shipments and chat online if you have questions. Go to [MyAccredoPatients.com](http://MyAccredoPatients.com) to log in or get started.