

Statement of transition

Patient name _____

Physician name _____

It is necessary for the patient to transition:

From:

- Epoprostenol sodium
- Flolan[®]
- Remodulin[®] (IV)
- Remodulin[®] (subcutaneous)
- Tyvaso[®]
- Veletri[®]
- Ventavis[®]

To:

- Epoprostenol sodium
- Flolan[®]
- Remodulin[®] (IV)
- Remodulin[®] (subcutaneous)
- Tyvaso[®]
- Veletri[®]
- Ventavis[®]

Please provide justification for this transition: _____

Physician signature _____

Date _____

Fax completed form to 800.711.3526.