

Please fax both pages of completed form to your team at 800.711.3526.

To reach your PAH team, call toll-free 888.200.2811, option 2, then option 1.

You can now monitor shipments and chat online if you have questions. Go to MyAccredoPatients.com to log in or get started.

Prescription & Enrollment Form
PAH Oral and Inhalation



Four simple steps to submit your referral.

1 Patient Information



Please provide copies of front and back of all medical and prescription insurance cards.

New patient Current patient

Patient's first name _____ Last name _____ Middle initial _____

Male Female Last 4 digits of SSN _____ Date of birth _____

Street address _____ Apt # _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____ E-mail address _____

Parent/guardian (if applicable) _____

Home phone _____ Cell phone _____ E-mail address _____

Alternate caregiver/contact _____

Home phone _____ Cell phone _____ E-mail address _____

OK to leave message with alternate caregiver/contact

Patient's primary language: English Other If other, please specify _____

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 address _____

Office contact and title _____

Office contact phone number _____ 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 (REQUIRED): _____

Diagnosis: ICD 127.0 - Pulmonary arterial hypertension (PAH) Idiopathic PAH Familial PAH

 ICD 127.21 - 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 _____

Patient's first name _____ Last name _____ Middle initial _____ Date of birth _____

Prescriber's first name _____ Last name _____ Phone _____

4 Prescribing Information

Medication	Strength/Formulation	Directions	Quantity/Refills
ambrisentan	5mg tablet 10mg tablet	Take one tablet by mouth once daily. Other _____	1-month supply 3-month supply Other _____ Refills _____
bosentan	62.5mg tablet 125mg tablet	Take 62.5mg by mouth twice daily x 4 weeks, then increase to maintenance dose of 125mg twice daily. Other _____	1-month supply Refills _____
bosentan	32mg tablet (available only as Tracleer)	Directions	28-day supply Refills _____
sildenafil	20mg tablet	Take one tablet by mouth three times a day. Other _____	1-month supply 3-month supply Other _____ Refills _____
sildenafil oral suspension	10mg/mL 112mL	Take 1mL (10mg) three times a day. Other _____	1-month supply 3-month supply Other _____ Refills _____
tadalafil	20mg tablet	Take two tablets by mouth daily. Other _____	1-month supply 3-month supply Other _____ Refills _____
Tyvaso® (treprostinil)	1.74mg/2.9mL ampule (0.6mg/mL) inhalation solution	PAH - Prescriber use this section for PAH prescription Target dose: 9 breaths (54mcg) to 12 breaths (72mcg), 4 times a day – Start with 3 breaths (18mcg) 4 times a day (if 3 breaths are not tolerated, use 1 to 2 breaths). Increase by additional 3 breaths at 1- to 2-week intervals, if tolerated, until the target dose of 9 breaths (54mcg) to 12 breaths (72mcg), 4 times a day. PH-ILD - Prescriber use this section for PAH prescription Target dose: 9 breaths (54mcg) to 12 breaths (72mcg), 4 times a day – Start with 3 breaths (18mcg) 4 times a day (if 3 breaths are not tolerated, use 1 to 2 breaths). Increase by additional 1 breath per week, if tolerated, until the target dose of 9 breaths (54mcg) to 12 breaths (72mcg), 4 times a day.	Tyvaso Inhalation System Starter Kit (28-day supply) Tyvaso Inhalation System Refill Kit (28-day supply) Refills _____ Prescriber may specify any alternative or additional dosing and titration instructions here:
Ventavis® (iloprost)	2.5mcg or 5mcg (10mcg/mL) inhalation via I-neb® AAD® System, as tolerated. 6 to 9 times per day during waking hours.	Start with 2.5mcg x 1. If tolerated, go to 5mcg (10mcg/mL) ongoing. If not tolerated, resume 2.5mcg. If patient is maintained at 5mcg (10mcg/mL) dose and repeatedly experience extended treatment times, consider transitioning to 5mcg (20mcg/mL). If patient is maintained at Ventavis 5mcg (10mcg/mL) for 1 month, consider transitioning to Ventavis 5mcg (20mcg/mL) starting at month 2, unless contacted by physician. Or please provide dosing instructions:	1-month supply Refills _____ Send one (1)* I-neb® AAD® System if this is an initial order.
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 <i>If nursing services will be required for therapy administration, the home health nurse will call for additional orders per state regulations.</i>			

Prescriber's signature required (sign below) (Physician attests this is his/her legal signature. NO STAMPS)

SIGN HERE

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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