Please fax both pages of completed form to your PAH 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 Infusion

accredo®

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 _____

Sex at birth: ☐ Male ☐ Female Preferred pronouns _____ 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 _____

Office/clinic/institution name _____

Prescriber info: Prescriber's first name _____ Last name _____

Prescriber's title _____ If NP or PA, under direction of Dr. _____

Office phone _____ Fax _____ NPI # _____ License # _____

Office contact and title _____ Office contact e-mail _____

Office street address _____ Suite # _____

City _____ State _____ Zip _____

Infusion location: ☐ Patient's home ☐ Prescriber's office ☐ Infusion site If infusion site, complete information below dotted line:

Infusion info: Infusion site name _____ Clinic/hospital affiliation _____

Site street address _____ Suite # _____

City _____ State _____ Zip _____

Infusion site contact _____ Phone _____ Fax _____ E-mail _____

3 Clinical Information

Primary ICD-10 code (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

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

Medication	Diluent	Dose and directions	Quantity/Refills
☐ Flolan (epoprostenol)	☐ pH12 sterile diluent for Flolan	**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.	☐ 1-month supply ☐ 3-month supply ☐ Other _____ Refills _____
☐ epoprostenol (generic Flolan)	☐ epoprostenol sterile diluent for injection		
☐ epoprostenol (generic Veletri)	☐ 0.9% sodium chloride ☐ sterile water for injection		
☐ treprostinil IV	☐ treprostinil sterile diluent for injection ☐ 0.9% sodium chloride ☐ epoprostenol sterile diluent for injection ☐ sterile water for injection		
☐ treprostinil subcut		**Continuous subcutaneous 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.	

☐ 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 infusion 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.

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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