Prescription & Enrollment Form

Pulmonary arterial hypertension (PAH)

accredo®

Four simple steps to submit your referral.

1 PATIENT INFORMATION

❑ New patient ❑ Current patient

Patient 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
❑ ambrisentan	❑ 5 mg tablet ❑ 10 mg tablet	❑ Take one tablet by mouth once daily ❑ Other _____	Dispense: ❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ bosentan	❑ 62.5 mg tablet ❑ 125 mg tablet	❑ Take 62.5 mg by mouth twice daily x 4 weeks, then increase to maintenance dose of 125 mg twice daily ❑ Other _____	Dispense: ❑ 1-month supply Refills _____
❑ bosentan	32 mg tablet (available only as Tracleer)	Directions _____	Dispense: ❑ 28-day supply Refills _____
❑ sildenafil	20 mg tablet	❑ Take one tablet by mouth three times a day. ❑ Other _____	Dispense: ❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ sildenafil oral suspension	10 mg/mL 112 mL	❑ Take 1 mL (10 mg) three times a day ❑ Other _____	Dispense: ❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ tadalafil	20 mg tablet	❑ Take two tablets by mouth daily. ❑ Other _____	Dispense: ❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ Tyvaso® (treprostinil)	2.9 mL amp administered via inhaler device	❑ Use 1 ampule per day. Inhale 3–9 breaths as tolerated four times daily. ❑ Other _____	Dispense: ❑ Starter kit x 1 month, 0 refills ❑ Refill kit: ❑ 1 month ❑ 3 months ❑ 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
❑ epoprostenol	CADD Legacy ❑ 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: ❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ Veletri®	CADD Legacy ❑ 0.9% sodium chloride ❑ sterile water for injections		
❑ treprostinil IV	CADD Legacy ❑ treprostinil sterile diluent for injection ❑ 0.9% sodium chloride ❑ epoprostenol sterile diluent for injection ❑ sterile water for injection		
❑ treprostinil IV	CADD MS3 ❑ 0.9% sodium chloride ❑ sterile water for injections		
❑ Remodulin® SubQ	CADD MS3		

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

PHYSICIAN SIGNATURE REQUIRED

Date _____ Substitution allowed _____ Date _____ Dispense as written _____

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 800.711.3526. To reach your PAH team, call toll-free 888.200.2811, option 2, then option 1.

You can now track shipments for all your Accredo patients. Go to https://prescribers.accredo.com and click "Help" to register.