



# Facsimile Transmittal Form - Prostacyclin Referral

Listed here is the documentation required for infused and inhaled prostacyclin Medicare claims submissions for patients with pulmonary arterial hypertension (PAH) in accordance with the Medicare Local Coverage Determination (LCD) guidelines. Since many patients with commercial health plan coverage may eventually become Medicare beneficiaries, Accredo reviews all new infused and inhaled prostacyclin patients with respect to the Medicare LCDs. The following documentation would be required.

Accredo also recommends that physician offices provide this documentation for all PAH patients as many patients may eventually end up on an inhaled or infused prostacyclin. This form provides a checklist of Medicare requirements for infused and inhaled prostacyclin referrals.

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Date: \_\_\_\_\_ Pages sent (including cover sheet): \_\_\_\_\_

### Check the boxes below as items are included in the return fax:

- Completed PAH referral form (go to **accredo.com** for the most up-to-date referral forms)
- PAH Diagnosis and diagnosis code clearly documented on the referral form
- Clinical documentation
  - H&P (current within the past 6 months) Date of H&P: \_\_\_\_\_
  - Right heart catheterization report

Yes	No	Are the following items in the right heart catheterization report?
<input type="checkbox"/>	<input type="checkbox"/>	Mean PA Pressure (or systolic/diastolic) >25 mm Hg at rest or ≥30 mm Hg with exertion
<input type="checkbox"/>	<input type="checkbox"/>	Cardiac output
<input type="checkbox"/>	<input type="checkbox"/>	Cardiac index
<input type="checkbox"/>	<input type="checkbox"/>	Pulmonary vascular resistance
<input type="checkbox"/>	<input type="checkbox"/>	Pulmonary capillary wedge pressure (or LVEDP) <15 mm Hg
<input type="checkbox"/>	<input type="checkbox"/>	Vasodilator testing

- Echocardiogram
- Calcium Channel Blocker Attestation with specific supporting clinical documentation
- For Medicare approval, patients with the following disease states will require supportive documentation that the PAH is out of proportion with the disease. Please check the box if the patient has the co-morbidity and if supportive documentation is provided.

No, no disease	Yes, has disease	Includes supportive documents	Co-morbid Condition
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep apnea (include Sleep Statement Sleep Study and CPAP Titration Schedule)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cardiomyopathy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	COPD (include Lung Statement Form, Chest CT Scan and PFT)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema (include Lung Chest CT Scan and PFT)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Interstitial lung disease (include Lung Statement Chest CT Scan and PFT)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sarcoidosis of the lung (include Lung Statement Chest CT Scan and PFT)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Left-sided valvular disease

- Check this box if Medicare Part B is currently the primary insurance for this referral

Fax Flolan®, Remodulin®, Tyvaso® and Veletri® to: **800.711.3526**. Fax Ventavis® to: **866.279.0669**.

If you have any questions, call **866.FIGHT.PH (866.344.4874)**.

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