

1 PATIENT INFORMATION

Name (First): _____ (Middle): _____ (Last): _____
 Date of Birth: _____ SSN: _____ Gender: Female Male
 Home Address: _____
 City: _____ State: _____ Zip: _____
 Shipping Address: (if different from above) _____
 City: _____ State: _____ Zip: _____
 Primary Phone: () _____ (best time to call) _____
 Secondary Phone: () _____ (best time to call) _____
 E-mail Address: _____
 Emergency Contact: _____ Relationship: _____ Phone: () _____

2 PHYSICIAN INFORMATION

Prescriber (First Name): _____ (Last Name): _____
 License #: _____ DEA #: _____
 NPI #: _____ UPIN #: _____
 Clinical/Hospital Affiliation: _____ Office Contact Person: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: () _____ Fax: () _____

3 INSURANCE INFORMATION (enter below or fax copy of patient's insurance card, both sides)

Primary Insurance: _____ **Secondary Insurance:** _____
 Employer Name: _____ Employer Name: _____
 Policy #: _____ Policy #: _____
 Group #: _____ Group #: _____
 ID #: _____ ID #: _____
 Insurance Co. Phone: _____ Insurance Co. Phone: _____
 Policy Holder/Relationship: _____ Policy Holder/Relationship: _____

4 MEDICAL INFORMATION/PATIENT EVALUATION

NYHA Functional Class: Class I Class II Class III Class IV
Allergies: Yes No If yes _____
Diagnosis:
ICD 416.0 — Pulmonary Arterial Hypertension (PAH): Idiopathic PAH Familial PAH
ICD 416.8 — Pulmonary Arterial Hypertension: Connective Tissue Disease HIV Congenital Heart Disease
 Other _____
Concomitant/Current Treatment:
 None ADCIRCA™ TYVASO™ Flolan® Epoprostenol® Letairis™ REMODULIN®
 Revatio® Tracleer® Ventavis® Other _____
Check/Attach copies of: Calcium-Channel Blocker Statement History and Physical Echocardiogram
 CT Scan, VQ Scan or Pulm Angiogram Right Heart Cath
Patient Weight: _____ lbs kg **Height:** _____
Patient Status: Out-patient In-patient Urgent

5 PRESCRIPTION INFORMATION

ADCIRCA™ (tadalafil) 20 mg tablets 2 tablets (40 mg po once daily) #60 x _____ Refills
Qty: 30-days (60 tablets) 60-days (120 tablets) 90-days (180 tablets)

REVATIO® Tablet QS **Qty:** 30 days 60 days 90 days 20 mg po TID Other _____
 Refills: One Year Other _____

TYVASO™ (treprostinil) Inhalation Solution
 Target dose: 9 breaths (54 mcg) QID – Start with 3 breaths (18 mcg) QID (if 3 breaths are not tolerated, use 1 to 2 breaths). Increase by 3 breaths at 1 to 2 week intervals, if tolerated, until the target dose of 9 breaths (54 mcg) QID.
Qty: TYVASO Inhalation System (Starter and refill kits, 28 day supply) x _____ Refills

REMODULIN® Remodulin (treprostinil sodium) Injection – Note nanogram/kilogram/minute indicated as ng/kg/min
Vial concentration: 1 mg/mL 2.5 mg/mL 5 mg/mL 10 mg/mL
Qty: Dispense 1 month of drug and supplies x _____ Refills

Subcutaneous infusion continuous over 24 hours
 Initiation dosage: _____ ng/kg/min Titrate by _____ ng/kg/min every _____ days until goal of _____ ng/kg/min is achieved
 Change infusion site every _____ days

IV infusion continuous over 24 hours
 Initiation dosage: _____ ng/kg/min Titrate by _____ ng/kg/min every _____ days until goal of _____ ng/kg/min is achieved

CVC care Dressing change every _____ days Per IV standard of care

Check one (0.9% sodium chloride will be used if no box is checked):
 0.9% sodium chloride for injection Flolan sterile diluent for injection Sterile water for injection

Pumps: 2 CADD-MS™ 3 Pumps 2 CADD-Legacy® Pumps 2 Crono Five Pumps

Therapy education orders (nurse training): **Location:** Hospital Out-patient clinic Home

IV EPOPROSTENOL™ Vial Concentration: 0.5 mg/mL 1.5 mg/mL **QTY: 1 Mo [IV Infusion Only]**
 Please send 2 vials sterile diluent for each day of mixing.
 Infuse continuously via external infusion pump 24 hours/day starting at a dose _____ ng/kg/min to a max _____ ng/kg/min
 Titrate dose by: _____ ng/kg/min at frequency _____ (Please specify frequency of dose titration)
 2 vials sterile diluent for each day of mixing QS Refills: One Year Other _____
 Infused via pump: CADD Legacy

IV Access Central Line Care per CuraScript protocol Central Line Care per specific protocol (please fax)

Therapy education orders: Location: Hospital Home Clinic Pre-teach needed

I certify that the PAH therapy ordered above is medically necessary, that it is safe and appropriate to administer in the home setting, and that I am personally supervising the care of this patient. **PHYSICIAN SIGNATURE REQUIRED TO VALIDATE PRESCRIPTIONS**

 Physician Signature – Dispense as Written

 Physician Signature – Substitution Permissible

Today's Date _____