

**DIAGNOSIS STATEMENT**

Patient's name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

As of today, \_\_\_\_\_/20\_\_\_\_, my patient has a confirmed diagnosis of Pulmonary Arterial Hypertension (PAH) with the following specifications:

- ICD-9: 416.0**    **OR**     **ICD-9: 416.8.** PAH associated with:
- IPAH
  - FPAH
  - Collagen vascular disease
  - Congenital heart disease
  - Portal hypertension
  - HIV infection
  - Drugs and toxins
  - Chronic pulmonary embolism
  - Others: \_\_\_\_\_

- NYHA Functional Class:**
- Class I     Class II     Class III     Class IV

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**Prescriber:** The section below is optional and only needs to be completed by you if applicable:

**Out of Proportion Statement**

This patient has co-morbidities which include \_\_\_\_\_  
However, the PAH manifestations appear to be out of proportion to those identified co-morbidities.

I hereby certify and attest that the above statements are true and accurate.

**Prescriber's name:** \_\_\_\_\_

**Prescriber's signature:** \_\_\_\_\_

**PLEASE FAX THE COMPLETED, SIGNED, AND DATED FORM TO 877-305-6745.**

*Disclaimer Statement: CMS and certain private insurance companies may not cover prescribed therapies if the PAH diagnosis is not confirmed and/or the prescribed therapy is deemed not medically necessary.*