CuraScript | PAH Therapy Enrollment Form

Phone: 866.474.8326 | Fax: 877.305.6745

1 PRESCRIBER INFORMATION

Today's Date: ______ Date Needed: ______ Prescriber: ______ Hospital/Clinic: ______

Address: ______ City: ______ State: ______ Zip: ______

Phone Number: ( ) ______ Fax Number: ( ) ______

Nurse Contact: ______ Preference: ☐ Fax ☐ Phone ☐ E-mail: ______

Physician Specialty: ______ NPI #: ______ E-mail: ______

Medicaid #: ______ ME #: ______ UPIN/DEA #: ______ State License #: ______

2 PATIENT INFORMATION

Last Name: ______ First Name: ______ Middle Initial: ______

Home Phone Number: ( ) ______ Work Phone Number: ( ) ______

Address: ______ City: ______ State: ______ Zip: ______

Shipping Address: (if different from home address) ______ ☐ Physician ☐ Home ☐ Other ______

Language Preference: ☐ English ☐ Spanish ☐ Other ______ Is patient working full time? ☐ Yes ☐ No Part time? ☐ Yes ☐ No ______

Social Security Number: ______ Sex: ☐ Female ☐ Male Date of Birth: ______

Emergency Contact: ______ Relationship: ______ Phone: ( ) ______

Patient Weight: ______ ☐ lbs ☐ kg Height: ______ ☐ ft/in ☐ m/cm Allergies: ______ ☐ No known allergies

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

Primary Insurance: ______

Name of Insured: ______

Policy #: ______

Group #: ______

Phone #: ______

Rx Drug Card #: ______

Secondary Insurance: ______

Name of Insured: ______

Policy #: ______

Group #: ______

Phone #: ______

Rx Drug Card #: ______

4 PRESCRIBING INFORMATION

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

☐ **IV EPOPROSTENOL™** Vial Concentration: ☐ 0.5 mg/mL ☐ 1.5mg/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.

Begin therapy on: ______ *(Specify an actual date, NOT ASAP)*

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 ______

5 MEDICAL INFORMATION AND PRIMARY DIAGNOSIS

☐ Calcium Channel Blocker Statement ☐ Chest X-ray ☐ Cardiac Catheterization

☐ History and Physical ☐ Lung Scan, CT Scan, VQ Scan or Pulm Angiogram

☐ Echocardiogram

NYHA Class:

☐ Class II ☐ Class III ☐ Class IV

☐ 6 minute walk: ______ Date ______ Meters ______

Diagnosis:

ICD 416.0 — Pulmonary Arterial Hypertension: ☐ Familial PAH ☐ Idiopathic PAH

ICD 416.8 — Pulmonary Arterial Hypertension associated with: ☐ HIV

☐ Connective Tissue Disease ☐ Congenital Heart ☐ Other ______

Current Treatment:

☐ None ☐ Remodulin® ☐ Tracleer® ☐ Flolan®

☐ Revatio® ☐ Letairis™ ☐ Other ______

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's Signature ______ Today's Date ______

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