



Fax: 1-877-305-6745  
Phone: 1-866-474-8326

### 1. PATIENT INFORMATION

Name (First) (Middle) (Last)

Date of birth SSN Gender:  Female  Male

Home address

City State ZIP

Shipping address (if different than above)

City State ZIP

Primary telephone (best time to call) Secondary telephone (best time to call)

E-mail address

Emergency contact Relationship Telephone

### 2. PHYSICIAN INFORMATION

Prescribing MD name (First) (Last)

License # DEA #

NPI # UPIN #

Clinical/Hospital affiliation Office contact person

Address

City State ZIP

Telephone Fax

Referring physician  No referring MD

City State ZIP

### 3. INSURANCE INFORMATION

**Primary insurance** Employer name

Policy # Group # ID #

Insurance company telephone Policy holder name/relationship

**Secondary insurance** Employer name

Policy # Group # ID #

Insurance company telephone Policy holder name/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™  Flolan®  Epoprostenol  Letairis™  REMODULIN®  Revatio™  
 Tracleer®  TYVASO™  Ventavis®  Other \_\_\_\_\_

**Check/Attach copies of**  
 Calcium-channel blocker statement  Chest x-ray  ANA results  
 Right heart catheterization  History and physical  Echocardiogram  Physician statement  
 Lung scan, CT scan, VQ scan, or pulm angiogram  Medicare acknowledgment form  
 Pain management protocol  6-minute walk test \_\_\_\_\_ meters

Weight: \_\_\_\_\_ kg/lb Height: \_\_\_\_\_ Diabetic:  Yes  No

**Patient status**  Out-patient  In-patient  Urgent

### 5. PRESCRIPTION INFORMATION

**ADCIRCA™ (tadalafil) 20 mg tablets**  
2 tablets (40 mg po QD) #60 X \_\_\_\_\_ refills  
**Quantity:**  30-day (60 tablets)  60-day (120 tablets)  90-day (180 tablets)

**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.  
**Quantity:**  TYVASO Inhalation System Starter Kit (28 day supply)  
 TYVASO Inhalation System Refill Kit (28 day supply) X \_\_\_\_\_ refills

**REMODULIN® (treprostinil sodium) Injection**  
**Vial concentration:**  1 mg/mL (20 mL vial)  2.5 mg/mL (20 mL vial)  
 5 mg/mL (20 mL vial)  10 mg/mL (20 mL vial)  
**Quantity:** Dispense 1 month of drug and supplies **Patient dosing weight:** \_\_\_\_\_ kg/lb

**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 q \_\_\_\_\_ days Palliative meds PRN \_\_\_\_\_

**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

I certify that the pulmonary arterial hypertension 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 \_\_\_\_\_ Dispense as written \_\_\_\_\_ Substitution allowed \_\_\_\_\_ Date \_\_\_\_\_  
(Physician attests this is his/her legal signature. NO STAMPS.) By signing, I certify that the above therapy is medically necessary.

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