Pulmonary Arterial Hypertension *(PAH)* - Orals
REFERRAL FORM

FAX REFERRAL TO: +1(844) 277-0049 **PHONE: +1(844) 650-5802**

1 PATIENTS INFORMATION *(Complete or include demographic sheet)*

Patient Name: ______________________ **DOB:** ______________ **Gender:** ☐ MALE ☐ FEMALE
Address: ______________________ **City/State/Zip:** ______________________
Primary Phone: ______________ **Email:** ______________ **SSN:** ______________ **Primary Language:** ______________
Emergency Contact: ______________ **Relationship to Patient:** ______________ **Phone:** ______________

2 INSURANCE *(Please attach **If Available** a copy of the Patients' insurance card(s) Front/ Back)*

Primary Insurance: ______________ **Policy No:** ______________ **Group:** ______________
Primary RX Insurance:______________ **ID No:**______________ **RX GRP:**______________ **RX BIN:**______________ **RX PCN:**______________

3 DIAGNOSIS AND CLINICAL INFORMATION

Diagnosis (ICD-10):

☐ I27.0 Primary Pulmonary Hypertension ☐ I27.20 Pulmonary Hypertension, Unspecified ☐ I27.21 Secondary Pulmonary Arterial Hypertension
☐ I27.24 Chronic Thromboemolic Pulmonary Hypertension ☐ I27.83 Eisenmenger's Syndrome ☐ I27.89 Other Specified Pulmonary Disease
☐ Other Code: ______________ Description ______________________

Prior Therapy: Is patient currently on another therapy for pulmonary hypertension? ☐ Yes ☐ No **If Yes**, name of drug(s): ______________

Patient Clinical Information:

New York Heart Association (NYHA) Functional Classification: ☐ I ☐ II ☐ III ☐ IV

6 Minute Walk Distance: __________ meters.

Drug Allergies:______________________ NKDA **Ht:** ____________in/cm **Wt:** ____________lbs/Kg

4 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSING & DIRECTIONS	QUANTITY	REFILLS
☐ **Adcirca** *(tadalafil)*	☐ 20 mg tablet	☐ Take 40 mg (2 tablets) once a day.	Q.S	1 YEAR
		☐ **Other:** ______________	Q.S	1 YEAR
☐ **Letairis** *(ambrisentan)*	☐ 5 mg tab	☐ Take one tablet by mouth once daily	Q.S	1 YEAR
	☐ 10 mg tab	☐ **Other:** ______________	Q.S	1 YEAR
☐ **Revatio** *(sildenafil)*	☐ 20 mg tablet	☐ Take 20 mg (1 tablet) three times a day.	Q.S	1 YEAR
		☐ **Other:** ______________	Q.S	1 YEAR
☐ **Tadliq** *(tadalafil)* suspension	☐ 20 mg/5 mL	☐ Take 40 mg (10 mL) orally once daily, with or without food	Q.S	1 YEAR
		☐ **Other:** ______________	Q.S	1 YEAR
☐ **Tracleer** *(bosentan)*	☐ 32 mg tab ☐ 62.5 mg tab	☐ Take 62.5 mg by mouth twice daily for 4 weeks, then increase to 125 mg twice daily ☐ thereafter	Q.S	1 YEAR
	☐ 125 mg tab	☐ **Other:** ______________	Q.S	1 YEAR
☐ **OTHER:** ______________	______________	______________	______	______

5 PRESCRIBER SIGNATURE REQUIRED *(STAMP SIGNATURE NOT ALLOWED)*

Prescriber Name: ______________________ **Title:** ☐ MD ☐ DO ☐ ND ☐ PA ☐ APRN **NPI:** ______________
Address: ______________________ **City/State/Zip:** ______________________
Phone: ______________ **Fax:** ______________ **Contact Person:** ______________

☐ **DISPENSE AS WRITTEN** ☐ **BRAND MEDICALLY NECESSARY** ☐ **DO NOT SUBSTITUTE**
☐ **NO SUBSTITUTION /** ☐ **DAW /** ☐ **MAY NOT SUBSTITUTE**

Prescriber's Signature: ______________ **Date:** ______________

☐ **May Substitute /** ☐ **Product Selection Permitted /** ☐ **Substitution Permissible**

Prescriber's Signature: ______________ **Date:** ______________

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution." NY & IA: electronic prescription required.

Prescribers are to comply with state-specific prescription regulations, which may include requirements for electronic prescribing, generic substitution, authorized prescription formats, and fax language. Noncompliance with these requirements may prompt follow-up communication with the prescriber.

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record.
I authorize IV Solutions RX and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future refills of the same prescription for the patient listed above. I understand that I can revoke the designation at any time by providing written notice to IV Solutions RX.
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