

For assistance, contact your pharmacy representative: _____ Phone: _____ (For providers only)

Note: This form is intended for prescriber use only, if faxed, the fax must come from prescriber's office or hospital (may not be faxed by patient).

Pulmonary Arterial Hypertension (PAH)

Prescription/Pharmacy Intake Form

Pharmacy: _____
Pharmacy Fax: _____ Pharmacy Phone: _____
Date Needed: _____ Ship To: Prescriber's Office Patient's Home Other: _____

PATIENT INFORMATION

Patient name: _____ DOB: _____ Male Female
Address: _____
City: _____ State: _____ Zip code: _____
Phone # (Daytime): _____ Phone # (Evening): _____
E-mail Address: _____ Case Manager: _____
Insurance provider (Please include copy of front and back of card): _____
ID #: _____ Policy/Group #: _____ Phone #: _____ Patient is eligible for Medicare
Name of Insured: _____ Employer: _____
Relationship to Patient: Self Other: _____ Prescription Card: Yes No Carrier: _____ Policy/Group #: _____

CLINICAL ASSESSMENT – Please complete ALL sections to avoid delays in filling prescription.

Patient is new to therapy Patient is restarting therapy Patient is currently on therapy Start date: _____
Primary ICD-10 Code: I27.0 I27.2 Other: _____
Diagnosis: I27.0 - Idiopathic PAH Familial PAH
I27.2 - Connective tissue disease Congenital heart disease HIV infection Other: _____
Concomitant medications for PAH: _____
Other therapies tried & failed (Please list): _____
WHO Group: _____ NYHA Functional Class: I II III IV
Current Weight: _____ lb kg Date: _____ Current Height: _____ in cm Date: _____
Allergies: _____

PRESCRIPTION INFORMATION

Medication	Strength	Dose & Directions	Quantity	Refills
<input type="checkbox"/> Adcirca <input type="checkbox"/> Tadalafil (generic)	20 mg tablet			
Please complete the REMS Patient Enrollment and Consent form at: https://www.ambrisentanrems.us.com or by calling: 1-888-417-3172				
<input type="checkbox"/> Letairis	<input type="checkbox"/> 5 mg tablet <input type="checkbox"/> 10 mg tablet			
Please complete the REMS Patient Enrollment and Consent form at: https://psambrisentanrems.com or by calling: 1-888-301-0333				
<input type="checkbox"/> Ambrisentan	<input type="checkbox"/> 5 mg tablet <input type="checkbox"/> 10 mg tablet			
<input type="checkbox"/> Revatio <input type="checkbox"/> Sildenafil (generic)	<input type="checkbox"/> 20 mg tablet <input type="checkbox"/> 10 mg/mL suspension (Brand only)			
<input type="checkbox"/> Tracleer <input type="checkbox"/> Bosentan (generic)	<input type="checkbox"/> 32 mg tablet for oral suspension (Brand only) <input type="checkbox"/> 62.5 mg tablet <input type="checkbox"/> 125 mg tablet			

PRESCRIBER INFORMATION

Prescriber's name: _____ Practice/facility: _____
Address: _____ City: _____ State: _____ Zip code: _____
Office contact: _____ Phone: _____ Fax: _____
Email: _____ Best time to call: _____ Preferred method of contact: Email Phone Fax
State license #: _____ DEA #: _____ NPI #: _____ Medicaid UPIN #: _____

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" or your state specific required language after their signature. I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge. Prescriber's signature required on one of the lines below.

Dispense as written

Substitution permitted

Date

The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

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