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
☐**Adcirca** ☐**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				
☐**Letairis**	☐5 mg tablet ☐10 mg tablet			
Please complete the REMS Patient Enrollment and Consent form at: https://psambrisentanrems.com or by calling: 1-888-301-0333				
☐**Ambrisentan**	☐5 mg tablet ☐10 mg tablet			
☐**Revatio** ☐**Sildenafil (generic)**	☐20 mg tablet ☐10 mg/mL suspension (Brand only)			
☐**Tracleer** ☐**Bosentan (generic)**	☐32 mg tablet for oral suspension (Brand only) ☐62.5 mg tablet ☐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.