Date Shipment Needed:_____ Ship To: ❑Patient ❑Prescriber
❑Nursing needed ❑Training needed ► All the supplies including syringes and needles will be dispensed if needed.

PULMONARY ARTERIAL HYPERTENSION REFERRAL FORM

PATIENT INFORMATION

Patient Name:		DOB:	Sex: ❑M ❑F	Weight:	❑lbs. ❑kg.
SSN:	Phone:	Allergies:			
Address:		City:	State:	Zip:	
Emergency Contact:	Phone:		❑**Please attach demographic information**		

PRESCRIBER INFORMATION

Prescriber:	NPI:	DEA:	State Lic:
Supervising Physician:	Practice Name:		
Address:	City:	State:	Zip:
Phone: Fax:	Key Office Contact:	Phone:	

DIAGNOSIS INFORMATION / MEDICAL ASSESSMENT

Primary Diagnosis: (ICD-10 Code & Description)
❑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**_____

- Has patient been treated *previously* for this condition? ❑Yes ❑No Medication(s): _____
- Is patient *currently* on therapy? ❑Yes ❑No Medication(s): _____
- Will patient stop taking the above medication(s) before starting the new medication? ❑Yes ❑No If yes:_____
- How long should patient wait before starting the new medication?_____
- Other medications patient is currently taking including OTC medications with dosage and direction (**or fax medication profile**):

INSURANCE INFORMATION

❑**Please attach front and back of patient's insurance card (medical and prescription)**

COPAY CARD ENROLLMENT

❑**Please check if enrolling in copay card** | **Copay ID:**

PRESCRIPTION INFORMATION

❑**Adcirca (tadalafil)** 20 mg tablet
❑Directions: 40 mg PO daily (2 tabs 1x day) **QTY:** 60 **Refills:**_____
❑Other:_____

❑**Ambrisentan** ❑5 mg tablet OR ❑10 mg tablet
❑Directions: Take one tablet PO daily **QTY**: 30 **Refills:**_____
❑Other:_____
Visit AmbrisentanRems.US.com to enroll your ***female patient*** *into the* ***Ambrisentan REMS Patient Enrollment and Consent Form***

❑**Revatio (sildenafil)** ❑20 mg tablet
❑Directions: 20 mg PO TID (1 tab 3x a day) **QTY:**_____ **Refills:**_____
❑Other:_____

❑**Revatio (sildenafil)** ❑10 mg/mL suspension
❑Directions:_____ **QTY:** 1 month **Refills:**_____
❑Other:_____

Prescriber's Signature:_____ ❑ DAW (Dispense as Written) **Date:** _____

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send prescription electronically or on official state prescription blank. In the event requested agent is not available through AcariaHealth, this prescription shall be forwarded to an eligible pharmacy.

Phone: 800.511.5144 ● Fax: 877.541.1503