

PULMONARY ARTERIAL HYPERTENSION REFERRAL FORM

PATIENT INFORMATION					
Patient Name:		DOB:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Weight:	<input type="checkbox"/> lbs. <input type="checkbox"/> kg.
SSN:	Phone:	Allergies:			
Address:		City:	State:	Zip:	
Emergency Contact:		Phone:	<input type="checkbox"/> 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)					
<input type="checkbox"/> I27.0 Primary Pulmonary Hypertension					
<input type="checkbox"/> I27.20 Pulmonary Hypertension, Unspecified					
<input type="checkbox"/> I27.21 Secondary Pulmonary Arterial Hypertension					
<input type="checkbox"/> I27.24 Chronic Thromboembolic Pulmonary Hypertension					
<input type="checkbox"/> I27.83 Eisenmenger's Syndrome					
<input type="checkbox"/> I27.89 Other Specified Pulmonary Disease					
<input type="checkbox"/> Other: _____					
<input type="checkbox"/> Has patient been treated <i>previously</i> for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No Medication(s): _____					
<input type="checkbox"/> Is patient <i>currently</i> on therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No Medication(s): _____					
<input type="checkbox"/> Will patient stop taking the above medication(s) before starting the new medication? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: _____					
<input type="checkbox"/> How long should patient wait before starting the new medication? _____					
<input type="checkbox"/> Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile): _____					
INSURANCE INFORMATION					
<input type="checkbox"/> Please attach front and back of patient's insurance card (medical and prescription)					
COPAY CARD ENROLLMENT					
<input type="checkbox"/> Please check if enrolling in copay card		Copay ID: _____			
PRESCRIPTION INFORMATION					
<input type="checkbox"/> Adcirca (tadalafil) 20 mg tablet		<input type="checkbox"/> Directions: 40 mg PO daily (2 tabs 1x day)		QTY: <u>60</u> Refills: _____	
<input type="checkbox"/> Other: _____					
<input type="checkbox"/> Ambrisentan <input type="checkbox"/> 5 mg tablet OR <input type="checkbox"/> 10 mg tablet		<input type="checkbox"/> Directions: Take one tablet PO daily		QTY: <u>30</u> Refills: _____	
<input type="checkbox"/> Other: _____					
Visit AmbrisentanRems.US.com to enroll your female patient into the Ambrisentan REMS Patient Enrollment and Consent Form					
<input type="checkbox"/> Revatio (sildenafil) <input type="checkbox"/> 20 mg tablet		<input type="checkbox"/> Directions: 20 mg PO TID (1 tab 3x a day)		QTY: _____ Refills: _____	
<input type="checkbox"/> Other: _____					
<input type="checkbox"/> Revatio (sildenafil) <input type="checkbox"/> 10 mg/mL suspension		<input type="checkbox"/> Directions: _____		QTY: <u>1 month</u> Refills: _____	
<input type="checkbox"/> 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.

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