Pulmonary Arterial Hypertension Enrollment Form

Phone: (844) 773-6779
Fax: (844) 533-1131
Website: www.InfuCareRx.com

PATIENT INFORMATION

Name:			
Address:			
City:	State/Zip:		
Telephone:	DOB:	M F	
Language Preference:	Wt:	Ht:	

PRESCRIBER INFORMATION

Prescribing Practitioner:		NPI:
Address:		
City:		State/Zip:
Office:		DEA:
Contact:	Phone:	Fax:

PLEASE FAX COPY OF: PRESCRIPTION FRONT & BACK CLINICAL NOTES MEDICAL CARD FRONT & BACK

PRIMARY INSURANCE INFORMATION

Member Name:	M F	DOB:
Address:	City:	

State:	Zip:	Telephone:	Alt. Telephone:
Member ID:	Rx Group #:	BIN#:	
PCN#:	Customer Service #:	Please attach a copy of the front and back of the patient's insurance card, if available.*****	

PRESCRIPTION

New Refill | Ship by: | Ship to: Patient's Home Doctor's Office Other:_______________________

Drug	Strength	Directions	Quantity	Refills
Adcirca®	20mg		1 month supply	
Revatio®	20 mg		1 month supply	

DIAGNOSIS AND CLINICAL INFORMATION

*****PLEASE FAX COPY OF PRESCRIPTION/MEDICAL CARD, FRONT AND BACK AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY**

Diagnosis Description and ICD10:

127.0 Primary Pulmonary Hypertension

Other: ____

Additional Clinical Information:

Expected Date of next dose: ____/____/________

Prior Medication Failed: ____

Length of Treatment:____

Reason for Discontinuation: ____

Allergies:

PRESCRIBING PRACTITIONER SIGNATURE

To Prescribing Practitioner: By signing this form and utilizing our services, you are also authorizing FOSRX/FAST to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies and co-pay foundations.

Prescribing Practitioner Signature:	Date:

Revised 8/2020