Pulmonary Arterial Hypertension Enrollment Form

Fax Referral To: 844-504-3278
Phone: 877-327-8881

Please cut along the dotted lines before submitting to a pharmacy.

Date Required: ______ Ship To: ☐ Patient ☐ MD Office ☐ Other: ______

PATIENT INFORMATION

Patient Name: ______
Address: ______
City, State, Zip: ______
Home Phone: ______
Cell Phone: ______
Date of Birth: ______ Gender: ______
Emergency Contact: ______ Phone: ______

PRESCRIBER INFORMATION

Prescriber Name: ______
Address: ______
City, State, Zip: ______
Phone: ______
Fax: ______
DEA #: ______ NPI #: ______
Contact Person: ______

INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card.)

Primary Insurance: ______ ID: ______ Group: ______
Secondary Insurance: ______ ID: ______ Group: ______
Prescription Card: ______ ID: ______ BIN: ______ PCN: ______

To better serve your patient and facilitate insurance authorization, please complete the pertinent sections:

PATIENT DIAGNOSIS/CLINICAL INFORMATION

☐ 127.0 Primary Pulmonary Hypertension
☐ Other: ______
Prior Medication Failed: ______
Length of Treatment: ______
Reason for Discontinuation: ______

Weight: ______ ☐ kg ☐ lbs Height: ______ ☐ cm ☐ in %BSA: ______
Allergies: ______ ☐ NKDA
Injection Training/Home Health RN visit is necessary. ☐ Yes ☐ No
Site of Care: ☐ Home ☐ MD Office ☐ Other: ______
Expected Date of next dose: ______

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Instructions	Quantity	Refills
Adcirca®	☐ 20mg tablet		☐ 1 month supply	
Revatio®	☐ 20 mg tablet		☐ 1 month supply	
Other:				

ADDITIONAL COMMENTS

Prescriber Signature: ______ **Date:** ______

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