Pulmonary Hypertension Enrollment Form

PATIENT INFORMATION

Patient Name: _____
Date of Birth: _____ / _____ / _____ ☐ Male ☐ Female
SSN: _____ - _____ - _____
Address: _____
City: _____ State: _____ Zip: _____

Phone: (_____) - _____ - _____
Email: _____
Preferred method of contact: ☐ Phone ☐ Email
Height: _____ in Weight: _____ lb Date: _____ / _____ / _____
Allergies: Medications: (Please attach additional pages if necessary)

PRESCRIPTION BENEFITS INFORMATION (Please attach front and back of insurance card)

Plan name: _____ ID#: _____ Group #: _____ RxBIN: _____ RxPCN: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Contact: _____ Clinic/Hospital Affiliation: _____

Phone: (_____) - _____ - _____ Fax: (_____) - _____ - _____
License #: _____
NPI #: _____
Medicaid Provider #: _____

PAHRX-20-01

CLINICAL CONSIDERATIONS

Diagnosis:
☐ I27.0 Primary pulmonary arterial hypertension
☐ I27.20 Pulmonary hypertension, unspecified
☐ I27.21 Secondary pulmonary arterial hypertension
☐ Other: _____
Diagnosis Date: ____ /____ / ____

NYHA Functional Classification: ☐ I ☐ II ☐ III ☐ IV
Mean Pulmonary Arterial Pressure: _____ Date: ____ /____ / ____
Pulmonary Artery Occlusion Pressure: _____ Date: ____ /____ / ____
Acute Pulmonary Vasoreactivity (as determined during right heart catheterization): _____ Date: ____ /____ / ____

Immunization History
☐ Influenza
Date: ____ /____ / ____

℞

Medication	Dose/Strength	Directions	Quantity	Refills
☐ **Adcirca®** (tadalafil)	☐ 20 mg tablets	☐ Take two tablets by mouth once daily		
☐ **Revatio®** (sildenafil)	☐ 20 mg tablets	☐ Take one tablet by mouth three times daily		

By signing below, I authorize the pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.
I also certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

Prescriber's Signature: _____ ☐ MD ☐ DO ☐ PA ☐ CRNP **Date:** ____ /____ / ____
NO STAMPS

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" on the prescription.

SHIPPING INFORMATION

Ship to: ☐ Patient ☐ Physician/Clinic Date Shipment Needed By: ____ /____ / ____