For assistance, contact your pharmacy representative:_______________ Phone: _______________ **(For providers only)**

PLEASE CONSIDER SENDING YOUR PRESCRIPTION ELECTRONICALLY. ALL OF OUR PHARMACY LOCATIONS ACCEPT ELECTRONIC PRESCRIPTIONS.

Note: This form is intended for prescriber use only, if faxed, the fax must come from prescriber's office or hospital **(may not be faxed by patient)**.

Pulmonary Arterial Hypertension (PAH)

Prescription/Pharmacy Intake Form

Pharmacy: _______________

Pharmacy Fax:_______________ Pharmacy Phone: _______________

Date Needed: _______________ **Ship To:** ☐Prescriber's Office ☐Patient's Home ☐Other:_______________

PATIENT INFORMATION

Patient name:_______________ DOB:_______________ ☐Male ☐Female

Address:_______________

City: _______________ State: _______________ Zip code: _______________

Phone # (Daytime): _______________ Phone # (Evening): _______________

E-mail Address: _______________ Case Manager: _______________

Insurance provider **(Please include copy of front and back of card)**: _______________

ID #: _______________Policy/Group #: _______________ Phone #: _______________ ☐Patient is eligible for Medicare

Name of Insured: _______________ Employer: _______________

Relationship to Patient: ☐Self ☐Other: _______________ Prescription Card: ☐Yes ☐No Carrier:_______________ Policy/Group #: _______________

CLINICAL ASSESSMENT Please complete ALL sections to avoid delays in filling prescription.

☐Patient is new to therapy ☐Patient is restarting therapy ☐Patient is currently on therapy Start date:_______________

Primary ICD-10 Code: ☐I27.0 ☐ I27.2 ☐Other:_______________

Diagnosis: I27.0 - ☐Idiopathic PAH ☐Familial PAH

I27.2 - ☐Connective tissue disease ☐Congenital heart disease ☐HIV infection ☐Other: _______________

Concomitant medications for PAH: _______________

Other therapies tried & failed (Please list):_______________

WHO Group: _______________ NYHA Functional Class: ☐I ☐II ☐III ☐IV

Current Weight: _______________☐lb ☐kg Date: _______________ Current Height:_______________ ☐in ☐cm Date: _______________

Allergies: _______________

PRESCRIPTION INFORMATION

Medication	Strength	Dose & Directions	Quantity	Refills
☐**Adcirca** ☐**Tadalafil (generic)**	20 mg tablet			
☐**Letairis**	Please complete the Letairis Patient Enrollment and Consent Form via LEAP at www.Letairis.com or by calling 1-866-664-LEAP (5327)			
☐**Revatio** ☐**Sildenafil (generic)**	☐20 mg tablet ☐10 mg/mL suspension (Brand only)			
☐**Tracleer** ☐**Bosentan (generic)**	☐32 mg tablet for oral suspension (Brand only) ☐62.5 mg tablet ☐125 mg tablet			

PRESCRIBER INFORMATION

Prescriber's name: _______________ Practice/facility: _______________

Address:_______________ City: _______________State:_______________Zip code: _______________

Office contact: _______________ Phone: _______________Fax:_______________

Email:_______________ Best time to call:_______________ Preferred method of contact: ☐Email ☐Phone ☐Fax

State license #:_______________DEA #:_______________ NPI #: _______________ Medicaid UPIN #:_______________

In order for a brand name product to be dispensed, the prescriber must handwrite **"Brand Necessary"** or **"Brand Medically Necessary"** or your state specific required language after their signature. I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge. Prescriber's signature required on one of the lines below.

_______________ Dispense as written

_______________ Substitution permitted

_______________ Date

The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

The document(s) accompanying this transmission may contain confidential health information that is legally protected. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless permitted or required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.

Drug names are the property of their respective owners.

©2019 AllianceRx Walgreens Prime All rights reserved. 110419