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

☐**Adcirca** ☐**Tadalafil (generic)**	20 mg tablet			
Please complete the REMS Patient Enrollment and Consent form at: https://www.ambrisentanrems.us.com or by calling: 1-888-417-3172				
☐**Letairis**	☐5 mg tablet ☐10 mg tablet			
Please complete the REMS Patient Enrollment and Consent form at: https://psambrisentanrems.com or by calling: 1-888-301-0333				
☐**Ambrisentan**	☐5 mg tablet ☐10 mg tablet			
☐**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. ©2021 AllianceRx Walgreens Prime All rights reserved. 021521