WELLPARTNER PHARMACY | PULMONARY ARTERIAL HYPERTENSION (PAH) ENROLLMENT FORM

Wellpartner

FAX FORM TO: 1.877.597.3070 | **PHONE:** 1.800.473.3516 | **EMAIL:** specialty@wellpartner.com

Complete the following or include demographic sheet.

1. PATIENT INFORMATION

Name:

Address:

City, State, ZIP:

Primary Phone: - - DOB: / /

Alternate Phone: - - Gender:

Email:

Primary Language: Last Four of SSN:

2. PRESCRIBER INFORMATION

Name:

DEA #: NPI #: State Lic. #:

Group or Hospital:

Address:

City, State, Zip:

Phone: - - Fax: - -

Contact Person: Phone: - -

3. INSURANCE INFORMATION

*Fax copy of **prescription** and **insurance cards** with this form, if available (front and back)*

Primary Insurance Company Name:

Primary Cardholder Name:

Relationship: ◯ Self ◯ Spouse/Partner ◯ Child/Dependent

Phone: - - Member ID: Group #:

Secondary Insurance Company Name:

Secondary Cardholder Name:

Relationship: ◯ Self ◯ Spouse/Partner ◯ Child/Dependent

Phone: - - Member ID: Group #:

4. DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: / / Ship to: ◯ Patient ◯ Office ◯ Other:

Date of Diagnosis: / /

◯ I27.0 Primary pulmonary hypertension

◯ I27.2 Other secondary pulmonary hypertension

◯ Secondary to:

Height (in/cm): Weight (lb/kg):

Allergies:

Current Medications:

New York Heart Association (NYHA) functional classification: ◯ I ◯ II ◯ III ◯ IV

Is patient currently on another therapy for PAH? ◯ Yes ◯ No

Nursing

◯ Not needed ◯ Pre-hospital/pre-home teaching ◯ In-hospital teaching ◯ Nursing follow-up

Start of care date: / / Number of visits:

5. PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills
◯ Adcirca (taladafil)	20 mg tablet	◯ Take two tablets (40 mg total) once daily. ◯ Other:		
◯ Revatio (sildenafil)	20 mg tablet	◯ Take one tablet 3 times daily. ◯ Other:		
◯ Revatio suspension 112 ml bottle	10 mg/ml suspension			
◯ Revatio	10 mg/12.5ml vial			
◯ Epoprostenol (LD)*	(LD)* These are limited distribution drugs that require additional handling. Please call (1.800.473.3516) for more information.			
◯ Letairis (LD)*				
◯ Opsumit (LD)*				
◯ Orenitram (LD)*				
◯ Remodulin (LD)*				
◯ Tracleer (LD)*				
◯ Tyvaso (LD)*				
◯ Uptravi (LD)*				
◯ Veletri (LD)*				
◯ Ventavis (LD)*				

Ancillary supplies and kits will be provided as needed for administration.

6. PRESCRIBER SIGNATURE

X / /

DISPENSE AS WRITTEN DATE

X / /

PRODUCT SUBSTITUTION PERMITTED DATE