Pulmonary Arterial Hypertension (PAH) Orals Enrollment Form

CVS specialty®

Fax Referral To: 1-877-232-5455
Address: 500 Ala Moana Blvd., Ste 1-A Honolulu, HI 96813

Phone: 1-800-896-1464

Six Simple Steps to Submitting a Referral

1 PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name: _____ DOB: _____
Address: _____City, State, ZIP Code: _____
Gender: ☐ Male ☐ Female
Preferred Contact Methods: ☐ Phone (to primary # provided below) ☐ Text (to cell # provided below) ☐ Email (to email provided below)
Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.
Primary Phone: _____ Alternate Phone: _____
If **Minor**, Parent/Caregiver/Guardian Name (Last, First): _____
Relationship to minor: _____
Email: _____ Last Four of SSN: _____ Primary Language: _____

2 PRESCRIBER INFORMATION

Prescriber's Name: _____ State License #: _____
NPI #: _____ DEA #: _____ Group or Hospital: _____
Address: _____ City, State, ZIP Code: _____
Phone: _____Fax_____ Contact Person: _____ Contact's Phone: _____

3 INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back)

4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: _____ Ship to: ☐ Patient ☐ Office ☐ Other: _____

Diagnosis (ICD-10):

Date of Diagnosis: _____

☐ I27.0 Primary Pulmonary Hypertension
☐ I27.20 Pulmonary Hypertension, Unspecified
☐ I27.21 Secondary Pulmonary Arterial Hypertension
☐ I27.24 Chronic Thromboemolic Pulmonary Hypertension
☐ I27.83 Eisenmenger's Syndrome
☐ I27.89 Other Specified Pulmonary Disease
☐ **Other Code: _____ Description _____**

Patient Clinical Information:

New York Heart Association (NYHA) Functional Classification: ☐ I ☐ II ☐ III ☐ IV
6 Minute Walk Distance: _____ meters
Is patient currently on another therapy for pulmonary hypertension? ☐ Yes ☐ No
If Yes, name of drug(s): _____
Weight: _____ lb/kg Height: _____ in/cm Allergies: _____

Pulmonary Arterial Hypertension (PAH) Oral Enrollment Form

Please Complete Patient and Prescriber Information

Patient Name: _____ Patient DOB: _____

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Adcirca (tadalafil)	20 mg tablet	☐ Take 40 mg (2 tablets) once a day. ☐ Other: _____	Quantity: 60 Refills: _____
☐ Adempas (riociguat)	NA	Please complete an Adempas Patient Enrollment and Consent form and indicate CVS Specialty as your preferred pharmacy provider. The form may be accessed at adempasREMS.com or by calling 1-855-4ADEMPAS (1-855-423-3672).	Quantity: 90 Refills: 0
☐ Ambrisentan	☐ 5 mg tab ☐ 10 mg tab	☐ Take one tablet by mouth once daily ☐ Other: _____ *Visit ambrisentanrems.com to enroll your female patient into the program*	Quantity: 30 Refills: _____
☐ Letairis (ambrisentan)	☐ 5 mg tab ☐ 10 mg tab	☐ Take one tablet by mouth once daily ☐ Other: _____ *Visit ambrisentanrems.com to enroll your female patient into the program*	Quantity: 30 Refills: _____
☐ Opsumit (macitentan)	NA	Please complete the Patient Enrollment and Consent form and indicate CVS Specialty as your preferred pharmacy provider. The form may be accessed at www.opsumitrems.com or by calling 1-866-228-3546.	Quantity: 0 Refills: 0
☐ Orenitram (treprostinil) extended release tablets	NA	Please use the Orenitram Enrollment Form on our website at CVSspecialty.com. Click on Health Care Professionals to access Enrollment Forms.	Quantity: 0 Refills: 0
☐ Revatio (sildenafil)	20 mg tablet	☐ Take 20 mg (1 tablet) three times a day. ☐ Other: _____	Quantity: 90 Refills:_____
☐ Revatio (sildenafil) suspension 112 mL bottle	10 mg/mL suspension	Other: _____	Quantity: One Month Refills: _____
☐ Bosentan	☐ 62.5 mg tab ☐ 125 mg tab	☐ Take 62.5 mg by mouth twice daily for 4 weeks, then increase to 125 mg twice daily thereafter ☐ Other: _____ *Visit bosentanremsprogram.com to enroll your patient into the program*	Quantity: 60 Refills: _____
☐ Tracleer (bosentan)	☐ 32 mg tab ☐ 62.5 mg tab ☐ 125 mg tab	☐ Take 62.5 mg by mouth twice daily for 4 weeks, then increase to 125 mg twice daily thereafter ☐ Other: _____ *Visit bosentanremsprogram.com to enroll your patient into the program*	Quantity: 60 Refills: _____
☐ Uptravi (selexipag) oral tablets	NA	Please use the Uptravi Enrollment Form on our website at CVSspecialty.com. Click on Health Care Professionals to access Enrollment Forms.	Quantity: _____ Refills: _____

☐ Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute **Prescriber's Signature: _____ Date: _____**	May Substitute / Product Selection Permitted / Substitution Permissible **Prescriber's Signature: _____ Date: _____**

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "**No Substitution**" _____ **ATTN: New York and Iowa providers,** please submit electronic prescription

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.