

Pulmonary Arterial Hypertension (PAH) Infused/Inhaled Enrollment Form



Fax Referral To: 1-877-943-1000
Email Referral To: PAH.Faxes@CVSHealth.com

Phone: 1-877-242-2738

Six Simple Steps to Submitting a Referral

1 PATIENT INFORMATION (Complete or include demographic sheet)

Patient Name: _____ DOB: _____ Gender: Male Female

Address: _____ City, State, ZIP Code: _____

Preferred Contact Methods: Phone (to primary # provided below) Text (to cell # provided below) Email (to email provided below)

Note: Carrier charges may apply. By providing the phone number(s) and email address above, you are consenting to receive automated calls, emails and/or text messages from CVS Specialty® about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.

Primary Phone: _____ Alternate Phone: _____

Email: _____ Last Four of SSN: _____ Primary Language: _____

Parent/Caregiver/Legal Guardian Name (Last, First): _____ Relationship to patient: _____

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 Thromboembolic 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: _____

Attach copies of: History and Physical Right Heart Catheterization Calcium Channel Blocker Statement Echocardiogram

Nursing: Not Needed Pre-hospital/Pre-home Teaching In-hospital Teaching Nursing Follow-up

Start of care date: _____ Number of visits: _____

Prostacyclin Referral Information:

Check the boxes below to designate which items are included in this fax:

PAH diagnosis and ICD-10 code (designated on PAH referral form)

Is Medicare Part B the primary insurance for this referral? Yes No

Clinical documentation

Current H&P (within 6 months); Date of H&P: _____

Right Heart Catheterization (RHC); Check below if included in the RHC report

Mean PA Pressure (or systolic/diastolic) > 25 mmHg at rest or > 30 mmHg with exertion

Cardiac Output

Cardiac Index

Pulmonary Vascular Resistance

Pulmonary Capillary Wedge Pressure (or LVEDP) < 15 mmHg

Echocardiogram

Calcium Channel Blocker statement with supporting documentation

Patients with the following disease states will require documentation that the PAH is out-of-proportion with the secondary disease: Left heart disease, valvular heart disease, lung disease, sarcoidosis and other co-morbidities, except for the ones listed in WHO Group I category

Pulmonary Arterial Hypertension (PAH) Infused/Inhaled Enrollment Form

Tyvaso, Tyvaso DPI, Ventavis, Flolan, Epoprostenol (Generic Flolan)

Please Complete Patient and Prescriber Information

Patient Name: _____ Patient DOB: _____ Patient Phone: _____
 Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

INHALED PRODUCTS:

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Tyvaso (treprostinil) Inhalation Solution	<input type="checkbox"/> Tyvaso Inhalation System Starter Kit <input type="checkbox"/> Tyvaso Refill Kit	<input type="checkbox"/> Start with 3 breaths (18 mcg) four times daily. Increase by 3-4 breaths at 1-2 week intervals, if tolerated, until the target dose of 9 breaths (54 mcg) four times daily. <input type="checkbox"/> Other: _____	Quantity: 28-day supply Refills: _____
<input type="checkbox"/> Tyvaso DPI (Treprostinil)	Tyvaso DPI Titration Kit <input type="checkbox"/> 16 mcg/32 mcg <input type="checkbox"/> 16 mcg/32 mcg/48 mcg Tyvaso DPI Maintenance Kit <input type="checkbox"/> 16 mcg <input type="checkbox"/> 32 mcg <input type="checkbox"/> 48 mcg <input type="checkbox"/> 64 mcg <input type="checkbox"/> 80 mcg: 32 mcg/48 mcg	Target dose: <input type="checkbox"/> 48 mcg <input type="checkbox"/> 64 mcg <input type="checkbox"/> Other ____ mcg per treatment session, 4 times daily <input type="checkbox"/> Start with one 16 mcg cartridge per treatment session, 4 times daily. Increase cartridge strength by 16 mcg per treatment session every week as tolerated to selected target dose. <input type="checkbox"/> Inhale one breath per cartridge 4 times daily <input type="checkbox"/> Other: _____	<input type="checkbox"/> Tyvaso DPI Titration Kit Quantity: 28-day supply Refills: 0 <input type="checkbox"/> Tyvaso DPI Maintenance Kit Quantity: 28-day supply Refills: _____
<input type="checkbox"/> Ventavis (iloprost) Inhalation Solution	NA	Please complete a Ventavis enrollment form and indicate CVS Specialty as your preferred pharmacy provider. The form may be accessed at www.4ventavis.com or by calling 1-866-228-3546.	Quantity: 0 Refills: 0

INFUSED THERAPIES:

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Flolan (epoprostenol) for injection	<input type="checkbox"/> 0.5 mg vial <input type="checkbox"/> 1.5 mg vial <input type="checkbox"/> Sterile diluent for Flolan <input type="checkbox"/> pH 12 sterile diluent for Flolan	<input type="checkbox"/> IV infusion continuous over 24 hours Initial dose: _____ ng/kg/min. Titrate by _____ ng/kg/min every _____ days until goal of _____ ng/kg/min achieved. Discharge dose: _____ ng/kg/min Concentration: _____ ng/mL Pump: <input type="checkbox"/> 2 CADD-Legacy Pumps <input type="checkbox"/> 2-CADD Solis Pumps CVC Care: <input type="checkbox"/> Dressing change every ___ days. <input type="checkbox"/> Per IV standard of care	Quantity: One-month supply of drug and supplies. Dosing weight: _____ kg/lb 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.

Pulmonary Arterial Hypertension (PAH) Infused/Inhaled Enrollment Form

Remodulin, Treprostinil (Generic Remodulin), Veletri, Epoprostenol (Generic Veletri)

Please Complete Patient and Prescriber Information

Patient Name: _____ Patient DOB: _____ Patient Phone: _____
 Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

INFUSED THERAPIES CONTINUED:

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Remodulin (treprostinil) for injection	<input type="checkbox"/> 1 mg/mL, 20 mL vial <input type="checkbox"/> 2.5 mg/mL, 20 mL vial <input type="checkbox"/> 5 mg/mL, 20 mL vial <input type="checkbox"/> 10 mg/mL, 20 mL vial	<input type="checkbox"/> SC continuous over 24 hours Initial dose: _____ ng/kg/min. Titrate by _____ ng/kg/min every _____ days until goal of _____ ng/kg/min achieved. Change infusion site every _____ days. Palliative med PRN _____ Pump: 2 CADD-MS3 pumps* *For pediatric or low weight patients ONLY <input type="checkbox"/> IV infusion continuous over 24 hours Initial dose: _____ ng/kg/min. Titrate by _____ ng/kg/min every _____ days until goal of _____ ng/kg/min achieved. Diluent: Check one (Sterile diluent for Remodulin will be used if no box is checked) <input type="checkbox"/> 0.9% NaCl for injection <input type="checkbox"/> Sterile Water for injection <input type="checkbox"/> Epoprostenol Sterile diluent <input type="checkbox"/> Sterile diluent for Remodulin Pump: <input type="checkbox"/> 2 CADD-Legacy Pumps <input type="checkbox"/> 2-CADD Solis Pumps <input type="checkbox"/> 2 CADD-MS 3 Pumps* *For pediatric or low weight patients ONLY CVC Care: <input type="checkbox"/> Dressing change every _____ days. <input type="checkbox"/> Per IV standard of care	Quantity: One-month supply of drug and supplies. Dosing weight: _____ kg/lb Refills: _____
<input type="checkbox"/> Treprostinil (Generic Remodulin)	<input type="checkbox"/> 1 mg/mL, 20 mL vial <input type="checkbox"/> 2.5 mg/mL, 20 mL vial <input type="checkbox"/> 5 mg/mL, 20 mL vial <input type="checkbox"/> 10 mg/mL, 20 mL vial	<input type="checkbox"/> IV infusion continuous over 24 hours Initial dose: _____ ng/kg/min. Titrate by _____ ng/kg/min every _____ days until goal of _____ ng/kg/min achieved. Diluent: Check one (Sterile diluent for Treprostinil will be used if no box is checked) <input type="checkbox"/> 0.9% NaCl for injection <input type="checkbox"/> Sterile Water for injection <input type="checkbox"/> Epoprostenol Sterile diluent <input type="checkbox"/> Sterile diluent for Treprostinil Pump: <input type="checkbox"/> 2 CADD-Legacy Pumps <input type="checkbox"/> 2-CADD Solis Pumps CVC Care: <input type="checkbox"/> Dressing change every _____ days. <input type="checkbox"/> Per IV standard of care	Quantity: One-month supply of drug and supplies. Dosing weight: _____ kg/lb Refills: _____
<input type="checkbox"/> Veletri (epoprostenol) for injection	<input type="checkbox"/> 0.5 mg vial <input type="checkbox"/> 1.5 mg vial	<input type="checkbox"/> IV infusion continuous over 24 hours Initial dose: _____ ng/kg/min. Titrate by _____ ng/kg/min every _____ days until goal of _____ ng/kg/min achieved. Discharge dose: _____ ng/kg/min Concentration: _____ ng/mL Diluent: Check one (0.9% Sodium Chloride will be used if no box is checked) <input type="checkbox"/> 0.9% NaCl for injection <input type="checkbox"/> Sterile Water for injection Pump: <input type="checkbox"/> 2 CADD-Legacy Pumps <input type="checkbox"/> 2-CADD Solis Pumps CVC Care: <input type="checkbox"/> Dressing change every _____ days. <input type="checkbox"/> Per IV standard of care	Quantity: 30-day supply of drug and supplies. Dosing weight: _____ kg/lb Refills: _____
<input type="checkbox"/> Epoprostenol (Generic Veletri)	<input type="checkbox"/> 0.5 mg vial <input type="checkbox"/> 1.5 mg vial	<input type="checkbox"/> IV infusion continuous over 24 hours Initial dose: _____ ng/kg/min. Titrate by _____ ng/kg/min every _____ days until goal of _____ ng/kg/min achieved. Discharge dose: _____ ng/kg/min Concentration: _____ ng/mL Diluent: Check one (0.9% Sodium Chloride will be used if no box is checked) <input type="checkbox"/> 0.9% NaCl for injection <input type="checkbox"/> Sterile Water for injection Pump: <input type="checkbox"/> 2 CADD-Legacy Pumps <input type="checkbox"/> 2-CADD Solis Pumps CVC Care: <input type="checkbox"/> Dressing change every _____ days. <input type="checkbox"/> Per IV standard of care	Quantity: 30-day supply of drug and supplies. Dosing weight: _____ kg/lb Refills: _____

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

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"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: _____
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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. **CONFIDENTIALITY NOTICE:** This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments. Plan member privacy is important to us. Our employees are trained regarding the appropriate way to handle members' private health information. This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with CVS Specialty and/or one of its affiliates.