

Pulmonary Arterial Hypertension (PAH) Orals 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/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: _____

Pulmonary Arterial Hypertension (PAH) Oral Enrollment Form

Please Complete Patient and Prescriber Information

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

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Adcirca (tadalafil)	20 mg tablet	<input type="checkbox"/> Take 40 mg (2 tablets) once a day. <input type="checkbox"/> Other: _____	Quantity: 60 Refills: _____
<input type="checkbox"/> 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: 0 Refills: 0
<input type="checkbox"/> Ambrisentan	<input type="checkbox"/> 5 mg tab <input type="checkbox"/> 10 mg tab	<input type="checkbox"/> Take one tablet by mouth once daily <input type="checkbox"/> Other: _____ Visit ambrisentanrems.com to enroll your female patient into the program	Quantity: 30 Refills: _____
<input type="checkbox"/> Bosentan	<input type="checkbox"/> 62.5 mg tab <input type="checkbox"/> 125 mg tab	<input type="checkbox"/> Take 62.5 mg by mouth twice daily for 4 weeks, then increase to 125 mg twice daily thereafter <input type="checkbox"/> Other: _____ Visit bosentanremsprogram.com to enroll your patient into the program	Quantity: 60 Refills: _____
<input type="checkbox"/> Letairis (ambrisentan)	<input type="checkbox"/> 5 mg tab <input type="checkbox"/> 10 mg tab	<input type="checkbox"/> Take one tablet by mouth once daily <input type="checkbox"/> Other: _____ Visit ambrisentanrems.com to enroll your female patient into the program	Quantity: 30 Refills: _____
<input type="checkbox"/> Liqrev (sildenafil) suspension 122 mL bottle	10 mg/1 mL	<input type="checkbox"/> Take 20 mg (2 mL) three times daily <input type="checkbox"/> Other: _____	Quantity: One Month Refills: _____
<input type="checkbox"/> 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.opsumithcp.com or at cvsspecialty.com/specialty-enrollment-forms.html , PAH – Opsumit	Quantity: 0 Refills: 0
<input type="checkbox"/> 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
<input type="checkbox"/> Revatio (sildenafil)	20 mg tablet	<input type="checkbox"/> Take 20 mg (1 tablet) three times a day. <input type="checkbox"/> Other: _____	Quantity: 90 Refills: _____
<input type="checkbox"/> Revatio (sildenafil) suspension 112 mL bottle	10 mg/mL	Other: _____	Quantity: One Month Refills: _____
<input type="checkbox"/> Tadalafil (tadalafil) suspension 150 mL bottle	20 mg/5 mL	<input type="checkbox"/> Take 40 mg (10 mL) orally once daily, with or without food <input type="checkbox"/> Other: _____	Quantity: One Month Refills: _____
<input type="checkbox"/> Tracleer (bosentan)	<input type="checkbox"/> 32 mg tab <input type="checkbox"/> 62.5 mg tab <input type="checkbox"/> 125 mg tab	<input type="checkbox"/> Take 62.5 mg by mouth twice daily for 4 weeks, then increase to 125 mg twice daily thereafter <input type="checkbox"/> Other: _____ Visit bosentanremsprogram.com to enroll your patient into the program	Quantity: 60 Refills: _____
<input type="checkbox"/> Upravi (selexipag) oral tablets	NA	Please use the Upravi Enrollment Form on our website at CVSSpecialty.com . Click on Health Care Professionals to access Enrollment Forms.	Quantity: 0 Refills: 0

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.

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.

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