Pulmonary Arterial Hypertension (PAH) Orals Enrollment Form

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

Phone: 1-808-254-2727
NCPDP: 1203417

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)

Is the Patient Insured? ☐ Yes ☐ No Is the Patient enrolled or eligible for Medicare/Medicaid? ☐ Yes ☐ No
Policy Holder's Name: ______________________ Policy Holder's DOB: __________ Relationship to Patient __________
Medical Insurance: ______________ Telephone: ____________ Policy ID: ____________ Group #: ______________
Prescription Insurance: ______________________________ Prescription Plan Telephone: ______________________
Policy ID: ______________________ Group #: ______________ RX BIN #: ____________ RX PCN #: __________
☐ Check box if patient is enrolled in manufacturer copay assistance If yes, please provide ID# ______________________

4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: ______________ Ship to: ☐ Patient ☐ Office ☐ Other: ______________________

Diagnosis (ICD-10):

Date of Diagnosis: __________

☐ I27.0 Primary Pulmonary Hypertension
☐ I27.21 Secondary Pulmonary Arterial Hypertension
☐ I27.83 Eisenmenger's Syndrome
☐ I27.20 Pulmonary Hypertension, Unspecified
☐ I27.24 Chronic Thromboemolic Pulmonary Hypertension
☐ 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: ______________________________

©2025 CVS Specialty and/or one of its affiliates. 75-42834B 02/27/25

Pulmonary Arterial Hypertension (PAH) Oral Enrollment Form

Please Complete Patient and Prescriber Information

Patient Name: ______________________________ Patient DOB: __________ Patient Phone: ______________________
Patient Address:____
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: 0 Refills: 0
☐ Ambrisentan	☐ 5 mg tab ☐ 10 mg tab	☐ Take one tablet by mouth once daily ☐ Other: ______________________	☐ Quantity: 30 ☐ Quantity: 90 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: ________
☐ Letairis (ambrisentan)	☐ 5 mg tab ☐ 10 mg tab	☐ Take one tablet by mouth once daily ☐ Other: ______________________	☐ Quantity: 30 ☐ Quantity: 90 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 opsumithcp.com or at cvsspecialty.com/specialty-enrollment-forms.html, PAH – Opsumit	
☐ Opsynvi (macitentan/tadalafil)	NA	Please complete the Patient Enrollment and Consent form and indicate CVS Specialty as your preferred pharmacy provider. The form may be accessed at opsynvihcp.com or at cvsspecialty.com/specialty-enrollment-forms.html, PAH – Opsynvi	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:________
☐ Tadliq (tadalafil) suspension 150 mL bottle	20 mg/5 mL	☐ Take 40 mg (10 mL) orally once daily, with or without food ☐ Other: ______________________	Quantity: One Month 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 complete the Patient Enrollment and Consent form and indicate CVS Specialty as your preferred pharmacy provider. The form may be accessed at uptravihcp.com or at cvsspecialty.com/specialty-enrollment-forms.html, PAH – Uptravi	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.
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.

©2025 CVS Specialty and/or one of its affiliates. 75-42834B 02/27/25