Pulmonary Arterial Hypertension (PAH) Orals Enrollment Form

CVS specialty®

Fax Referral To: 1-855-297-1270 **Phone:** 1-888-280-1190
Address: 6020 Ave Roberto Sanchez Vilella Carolina, PR 00982 **NCPDP:** 4026325

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
☐ I27.20 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: _____ 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.