

# Pulmonary Arterial Hypertension (PAH) Infused/Inhaled 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/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, Epoprostenol (Generic Flolan)

## Please Complete Patient and Prescriber Information

Patient Name: \_\_\_\_\_ Patient DOB: \_\_\_\_\_ Patient Phone: \_\_\_\_\_

Patient Address: \_\_\_\_\_

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: _____

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 <b>Prescriber's Signature:</b> _____ <b>Date:</b> _____	May Substitute / Product Selection Permitted / Substitution Permissible <b>Prescriber's Signature:</b> _____ <b>Date:</b> _____
<b>CA, MA, NC &amp; PR:</b> Interchange is mandated unless Prescriber writes the words "No Substitution" _____ <b>ATTN: New York and Iowa providers,</b> 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: \_\_\_\_\_

Patient Address: \_\_\_\_\_

Prescriber Name: \_\_\_\_\_ Prescriber Phone: \_\_\_\_\_

### 5 PRESCRIPTION INFORMATION

#### INFUSED THERAPIES:

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 <b>Prescriber's Signature:</b> _____ <b>Date:</b> _____	May Substitute / Product Selection Permitted / Substitution Permissible <b>Prescriber's Signature:</b> _____ <b>Date:</b> _____
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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.

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