# Pulmonary Arterial Hypertension (PAH) Infused/Inhaled Enrollment Form

CVS specialty®

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

**Phone:** 1-800-896-1464

## Six Simple Steps to Submitting a Referral

### 1 PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name: _____ DOB: _____
Address: _____City, State, ZIP Code: _____
Gender: ☐ Male ☐ Female
Preferred Contact Methods: ☐ Phone (to primary # provided below) ☐ Text (to cell # provided below) ☐ Email (to email provided below)
*Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.*
Primary Phone: _____ Alternate Phone: _____
If **Minor**, Parent/Caregiver/Guardian Name (Last, First): _____
**Relationship to minor**: _____
Email: _____ Last Four of SSN: _____ Primary Language: _____

### 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 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: _____
**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, Ventavis, Flolan, Epoprostenol (Generic Flolan), Remodulin**

**Please Complete Patient and Prescriber Information**

Patient Name: _____ Patient DOB: _____

Prescriber Name: _____ Prescriber Phone: _____

## 5 PRESCRIPTION INFORMATION

**INHALED PRODUCTS:**

| MEDICATION | STRENGTH | DOSE & DIRECTIONS | QUANTITY/REFILLS |
|---|---|---|---|
| ☐ Tyvaso (treprostinil) Inhalation Solution | ☐ Tyvaso Inhalation System Starter Kit<br>☐ Tyvaso Refill Kit | ☐ 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.<br>☐ Other: _____ | Quantity: 28-day supply<br>Refills: _____ |
| ☐ 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<br>Refills: 0 |

**INFUSED THERAPIES:**

| MEDICATION | STRENGTH | DOSE & DIRECTIONS | QUANTITY/REFILLS |
|---|---|---|---|
| ☐ Flolan (epoprostenol) for injection | ☐ 0.5 mg vial<br>☐ 1.5 mg vial<br>☐ Sterile diluent for Flolan<br>☐ pH 12 sterile diluent for Flolan | ☐ IV infusion continuous over 24 hours<br>Initial dose: _____ ng/kg/min. Titrate by _____ng/kg/min every _____ days until goal of _____ ng/kg/min achieved.<br>Discharge dose: _____ ng/kg/min Concentration: _____ ng/mL<br>Pump: 2 CADD-Legacy Pumps<br>CVC Care:<br>☐ Dressing change every ___ days. ☐ Per IV standard of care | Quantity: One-month supply of drug and supplies.<br>Dosing weight: _____ kg/lb<br>Refills: _____ |
| ☐ Epoprostenol (Generic Flolan) | ☐ 0.5 mg vial<br>☐ 1.5 mg vial<br>☐ Epoprostenol diluent | ☐ IV infusion continuous over 24 hours<br>Initial dose: _____ ng/kg/min. Titrate by _____ng/kg/min every _____ days until goal of _____ ng/kg/min achieved.<br>Discharge dose: _____ ng/kg/min Concentration: _____ ng/mL<br>Pump: 2 CADD-Legacy Pumps<br>CVC Care:<br>☐ Dressing change every ___ days. ☐ Per IV standard of care | Quantity: One-month supply of drug and supplies.<br>Dosing weight: _____ kg/lb<br>Refills: _____ |
| ☐ Remodulin (treprostinil) for injection | ☐ 1 mg/mL, 20 mL vial<br>☐ 2.5 mg/mL, 20 mL vial<br>☐ 5 mg/mL, 20 mL vial<br>☐ 10 mg/mL, 20 mL vial | ☐ SC continuous over 24 hours<br>Initial dose: _____ ng/kg/min. Titrate by _____ng/kg/min every _____ days until goal of _____ ng/kg/min achieved.<br>Change infusion site every _____ days.<br>Palliative med PRN _____<br>Pumps: 2 CADD-MS3 pumps<br>☐ IV infusion continuous over 24 hours<br>Initial dose: _____ ng/kg/min. Titrate by _____ng/kg/min every _____ days until goal of _____ ng/kg/min achieved.<br>Diluent: Check one (Sterile diluent for Remodulin will be used if no box is checked)<br>☐ 0.9% NaCl for injection ☐ Sterile Water for injection<br>☐ Epoprostenol Sterile diluent ☐ Sterile diluent for Remodulin<br>Pump:<br>☐ 2 CADD-Legacy Pumps ☐ 2 CADD-MS 3 Pumps<br>CVC Care:<br>☐ Dressing change every ____ days. ☐ Per IV standard of care | Quantity: One-month supply of drug and supplies.<br>Dosing weight: _____ kg/lb<br>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<br>**Prescriber's Signature: _____Date: _____** | May Substitute / Product Selection Permitted / Substitution Permissible<br>**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

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

**Please Complete Patient and Prescriber Information**

Patient Name: _____ Patient DOB: _____

Prescriber Name: _____ Prescriber Phone: _____

## 5 PRESCRIPTION INFORMATION

**INFUSED THERAPIES CONTINUED:**

| MEDICATION | STRENGTH | DOSE & DIRECTIONS | QUANTITY/REFILLS |
|---|---|---|---|
| ☐ Treprostinil (Generic Remodulin) | ☐ 1 mg/mL, 20 mL vial<br>☐ 2.5 mg/mL, 20 mL vial<br>☐ 5 mg/mL, 20 mL vial<br>☐ 10 mg/mL, 20 mL vial | ☐ IV infusion continuous over 24 hours<br>Initial dose: _____ ng/kg/min. Titrate by _____ng/kg/min every _____ days until goal of _____ ng/kg/min achieved.<br>Diluent: Check one (Sterile diluent for Treprostinil will be used if no box is checked)<br>☐ 0.9% NaCl for injection ☐ Sterile Water for injection<br>☐ Epoprostenol Sterile diluent ☐ Sterile diluent for Treprostinil<br>Pump: 2 CADD-Legacy Pumps<br>CVC Care:<br>☐ Dressing change every ___ days. ☐ Per IV standard of care | Quantity: One-month supply of drug and supplies.<br>Dosing weight: _____ kg/lb<br>Refills: _____ |
| ☐ Veletri (epoprostenol) for injection | ☐ 0.5 mg vial<br>☐ 1.5 mg vial | ☐ IV infusion continuous over 24 hours<br>Initial dose: _____ ng/kg/min. Titrate by _____ng/kg/min every _____ days until goal of _____ ng/kg/min achieved.<br>Discharge dose: _____ ng/kg/min Concentration: _____ ng/mL<br>Diluent: Check one (0.9% Sodium Chloride will be used if no box is checked)<br>☐ 0.9% NaCl for injection ☐ Sterile Water for injection<br>Pump: 2 CADD-Legacy Pumps<br>CVC Care:<br>☐ Dressing change every ___ days. ☐ Per IV standard of care | Quantity: 30-day supply of drug and supplies.<br>Dosing weight: _____ kg/lb<br>Refills: _____ |
| ☐ Epoprostenol (Generic Veletri) | ☐ 0.5 mg vial<br>☐ 1.5 mg vial | ☐ IV infusion continuous over 24 hours<br>Initial dose: _____ ng/kg/min. Titrate by _____ng/kg/min every _____ days until goal of _____ ng/kg/min achieved.<br>Discharge dose: _____ ng/kg/min Concentration: _____ ng/mL<br>Diluent: Check one (0.9% Sodium Chloride will be used if no box is checked)<br>☐ 0.9% NaCl for injection ☐ Sterile Water for injection<br>Pump: 2 CADD-Legacy Pumps<br>CVC Care:<br>☐ Dressing change every ___ days. ☐ Per IV standard of care | Quantity: 30-day supply of drug and supplies.<br>Dosing weight: _____ kg/lb<br>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<br>**Prescriber's Signature: _____Date: _____** | May Substitute / Product Selection Permitted / Substitution Permissible<br>**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.