aleracare
advanced specialty pharmacy

Pulmonary Arterial Hypertension
Referral Form

Patient Information			Prescriber Information	
Patient Name:	DOB:		Prescriber's Name:	
Address:			NPI#:	
City:	State:	Zip:	DEA#:	License#:
Phone:	Alternate Phone:	SSN:	Address:	
Height: Weight:	Allergies:		Phone:	Fax:
Emergency Contant:	Phone:		Contact Person:	

Is the patient pregnant, planning a pregnancy or nursing: ◯ Yes ◯ No

Does the patient need interpreter services: ◯ Yes ◯ No

Documentation (Required)

◯ Insurance Card (front and back) ◯ Current Medications ◯ History/Progress Notes

Specific Labs Needed (note: send ALL labs, must include specific labs listed here)

◯ Other: _____

Clinical Consideration

Diagnosis (ICD 10): ◯ 127.0 Primary pulmonary hypertension

◯ **Idiopathic** ◯ **Familial**

127.2 Other secondary pulmonary hypertension

◯ **Connective Tissue Disorder** ◯ **HIV** ◯ **CTEPH** ◯ **Associated**

Other (please specify): _____

Date Of Diagnosis: _____

NYHA Functional Classification: ◯ I ◯ II ◯ III ◯ IV

Mean PAP: _____

PAOP: _____

Acute Pulmonary Vasoreactivity: _____

Start Date: _____ **Review Date:** _____

Medication	Dose	Directions for Use	Qty	Refills
◯ **ADCIRCA®** (Tadalafil)	◯ 20 mg Tablet			
◯ **VELETRI®** (Epoprostenol Sodium)				
◯ **REMODULIN®** (Treprostinil Sodium)				
◯ **REVATIO®** (Sildenafil)	◯ 20 mg Tablet			
◯ **TYVASO®** (Treprostinil Inhalation Solution)				
◯ **LETAIRIS®** (Ambrisentan)				
◯ **TRACLEER®** (Bosentan)				
◯ **VENTAVIS®** (Iloprost)				

By signing this form I authorize AleraCare and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so release clinical information via phone to the appropriate third party payer.

Prescriber's Signature **Date**