Date: _____	**Pulmonary Hypertension**	

PATIENT INFORMATION:					
Last Name:	First Name:	Home Phone:		Mobile:	
Home Address:		City:	State:		Zip:
Date of Birth:	Gender:	Weight:	Height:	Language:	
Emergency Contact Name:		Relationship:		Number:	

HEATLHCARE PROVIDER INFORMATION				
Practice Name:	Dr Name:	Phone:	Fax	
Address:	City:	State:	Zip:	
NPI:	DEA:	License:	UPIN:	
Nurse/Key Contact:		Number:	Email:	

INSURANCE INFORMATION		
Insurance Name:	Contact Number:	
Cardholder Name:	ID Number:	PCN:
Cardholder DOB:	Group Number:	BIN:
☐ Attach a Copy of Both Sides of the Patient's Insurance Card (s)		

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills
☐ Adcirca (tadalafil)	☐ 20mg tablet	☐ Take 40mg (2 tablets) PO once daily ☐ Other: _____		
☐ Letairis (ambrisentan)	☐ 5 mg tablet ☐ 10 mg tablet	☐ Take 5mg (1 tablet) PO once daily ☐ Take 10mg (1 tablet) PO once daily		
☐ Revatio (sildenafil)	☐ 20mg tablet	☐ Take 20mg (1 tablet) PO three times daily ☐ Other: _____		
☐ Revatio (sildenafil)	☐ 10mg/ml suspension	☐ Take 5mg (0.5 ml) PO three times daily ☐ Take 20mg (2 ml) PO three times daily ☐ Other: _____	☐ Bottle (112ml) ☐ Other:_____	
☐ Tracleer (Bosentan)	☐ 32 mg tablet ☐ 62.5 mg tablet ☐ 125 mg tablet	☐ **Initial Dose:** Take 62.5mg PO twice daily for 4 weeks ☐ **Maintenance Dose:** Take 62.5mg PO twice daily ☐ **Maintenance Dose:** Take 125mg PO twice daily	☐ 60 ☐ 180	

CLINICAL INFORMATION

Diagnosis: ☐ 127.0 Primary pulmonary hypertension: ☐ Familial PAH ☐ Idiopathic PAH

☐ 127.2 Secondary pulmonary hypertension: ☐ CHD ☐ Portal hypertension ☐ HIV ☐ Drugs/toxins ☐ Other: _____

☐ Other ICD-10: _____

☐ New to therapy ☐ Restart ☐ Currently on therapy **Need Date**: _____ **Ship To**: ☐ Patient ☐ Dr Office ☐ Other: _____

Previous Tried Meds _____ **Current Meds:** _____

New York Association (NYHA) Functional Class: ☐ I ☐ II ☐ III ☐ IV 6 Minute Walk Distance: _____

☐ **Female of Reproductive Potential:** Confirmed pregnancy test: ☐ Yes ☐ No **Allergies:** _____

PRESCRIBER SIGNATURE: _____ **DATE:**_____

☐ Product substitution permitted ☐ Dispense as written ***Stamp signature not allowed, physician signature required *** Verbal Readback ☐ Yes ☐ No