Pulmonary Arterial Hypertension (PAH) Infused/Inhaled Enrollment Form

CVS specialty®

Fax Referral To: 1-877-943-1000
Email Referral To: PAH.Faxes@CVSHealth.com

Phone: 1-877-242-2738

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 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, Tyvaso DPI, Ventavis, Flolan, Epoprostenol (Generic Flolan)

Please Complete Patient and Prescriber Information

Patient Name: _____ Patient DOB: _____ Patient Phone: _____

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

INHALED PRODUCTS:

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Tyvaso (treprostinil) Inhalation Solution	☐ Tyvaso Inhalation System Starter Kit ☐ 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. ☐ Other: _____	Quantity: 28-day supply Refills: _____
☐ Tyvaso DPI (Treprostinil)	Tyvaso DPI Titration Kit ☐ 16 mcg/32 mcg ☐ 16 mcg/32 mcg/48 mcg Tyvaso DPI Maintenance Kit ☐ 16 mcg ☐ 32 mcg ☐ 48 mcg ☐ 64 mcg ☐ 80 mcg: 32 mcg/48 mcg	Target dose: ☐ 48 mcg ☐ 64 mcg ☐ Other ___ mcg per treatment session, 4 times daily ☐ 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. ☐ Inhale one breath per cartridge 4 times daily ☐ Other: _____	☐ Tyvaso DPI Titration Kit Quantity: 28-day supply Refills: 0 ☐ Tyvaso DPI Maintenance Kit Quantity: 28-day supply 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 Refills: 0

INFUSED THERAPIES:

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Flolan (epoprostenol) for injection	☐ 0.5 mg vial ☐ 1.5 mg vial ☐ Sterile diluent for Flolan ☐ pH 12 sterile diluent for Flolan	☐ 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 Pump: ☐ 2 CADD-Legacy Pumps ☐ 2-CADD Solis Pumps CVC Care: ☐ Dressing change every ___ days. ☐ Per IV standard of care	Quantity: One-month 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

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.

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: _____

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

INFUSED THERAPIES CONTINUED:

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Remodulin (treprostinil) for injection	☐ 1 mg/mL, 20 mL vial ☐ 2.5 mg/mL, 20 mL vial ☐ 5 mg/mL, 20 mL vial ☐ 10 mg/mL, 20 mL vial	☐ 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 ☐ 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) ☐ 0.9% NaCl for injection ☐ Sterile Water for injection ☐ Epoprostenol Sterile diluent ☐ Sterile diluent for Remodulin Pump: ☐ 2 CADD-Legacy Pumps ☐ 2-CADD Solis Pumps ☐ 2 CADD-MS 3 Pumps* *For pediatric or low weight patients ONLY CVC Care: ☐ Dressing change every ____ days. ☐ Per IV standard of care	Quantity: One-month supply of drug and supplies. Dosing weight: _____ kg/lb Refills: _____
☐ Treprostinil (Generic Remodulin)	☐ 1 mg/mL, 20 mL vial ☐ 2.5 mg/mL, 20 mL vial ☐ 5 mg/mL, 20 mL vial ☐ 10 mg/mL, 20 mL vial	☐ 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) ☐ 0.9% NaCl for injection ☐ Sterile Water for injection ☐ Epoprostenol Sterile diluent ☐ Sterile diluent for Treprostinil Pump: ☐ 2 CADD-Legacy Pumps ☐ 2-CADD Solis Pumps CVC Care: ☐ Dressing change every ___ days. ☐ Per IV standard of care	Quantity: One-month supply of drug and supplies. Dosing weight: _____ kg/lb Refills: _____
☐ Veletri (epoprostenol) for injection	☐ 0.5 mg vial ☐ 1.5 mg vial	☐ 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) ☐ 0.9% NaCl for injection ☐ Sterile Water for injection Pump: ☐ 2 CADD-Legacy Pumps ☐ 2-CADD Solis Pumps CVC Care: ☐ Dressing change every ___ days. ☐ Per IV standard of care	Quantity: 30-day supply of drug and supplies. Dosing weight: _____ kg/lb Refills: _____
☐ Epoprostenol (Generic Veletri)	☐ 0.5 mg vial ☐ 1.5 mg vial	☐ 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) ☐ 0.9% NaCl for injection ☐ Sterile Water for injection Pump: ☐ 2 CADD-Legacy Pumps ☐ 2-CADD Solis Pumps CVC Care: ☐ Dressing change every ___ days. ☐ 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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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. Plan member privacy is important to us. Our employees are trained regarding the appropriate way to handle members' private health information. This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with CVS Specialty and/or one of its affiliates.