

FAX FORM TO: 1.877.597.3070

PHONE: 1.800.473.3516

EMAIL: specialty@wellpartner.com

Complete the following or include demographic sheet.

1. PATIENT INFORMATION

Name:			
Address:			
City, State, ZIP:			
Primary Phone:	- -	DOB:	/ /
Alternate Phone:	- -	Gender:	
Email:			
Primary Language:	Last Four of SSN:		

2. PRESCRIBER INFORMATION

Name:			
DEA #:	NPI #:	State Lic. #:	
Group or Hospital:			
Address:			
City, State, Zip:			
Phone:	- -	Fax:	- -
Contact Person:	Phone:		- -

3. INSURANCE INFORMATION

Fax copy of prescription and insurance cards with this form, if available (front and back)

Primary Insurance Company Name:	Secondary Insurance Company Name:
Primary Cardholder Name:	Secondary Cardholder Name:
Relationship: <input type="radio"/> Self <input type="radio"/> Spouse/Partner <input type="radio"/> Child/Dependent	Relationship: <input type="radio"/> Self <input type="radio"/> Spouse/Partner <input type="radio"/> Child/Dependent
Phone: - - Member ID: Group #:	Phone: - - Member ID: Group #:

4. DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: / /	Ship to: <input type="radio"/> Patient <input type="radio"/> Office <input type="radio"/> Other:
Date of Diagnosis: / /	New York Heart Association (NYHA) functional classification: <input type="radio"/> I <input type="radio"/> II <input type="radio"/> III <input type="radio"/> IV
<input type="radio"/> I27.0 Primary pulmonary hypertension	Is patient currently on another therapy for PAH? <input type="radio"/> Yes <input type="radio"/> No
<input type="radio"/> I27.2 Other secondary pulmonary hypertension	Nursing
<input type="radio"/> Secondary to:	<input type="radio"/> Not needed <input type="radio"/> Pre-hospital/pre-home teaching <input type="radio"/> In-hospital teaching <input type="radio"/> Nursing follow-up
Height (in/cm): Weight (lb/kg):	Start of care date: / / Number of visits:
Allergies:	
Current Medications:	

5. PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills
<input type="radio"/> Adcirca (taladafil)	20 mg tablet	<input type="radio"/> Take two tablets (40 mg total) once daily. <input type="radio"/> Other:		
<input type="radio"/> Revatio (sildenafil)	20 mg tablet	<input type="radio"/> Take one tablet 3 times daily. <input type="radio"/> Other:		
<input type="radio"/> Revatio suspension 112 ml bottle	10 mg/ml suspension			
<input type="radio"/> Revatio	10 mg/12.5ml vial			
<input type="radio"/> Epoprostenol (LD)*	(LD)* These are limited distribution drugs that require additional handling. Please call (1.800.473.3516) for more information.			
<input type="radio"/> Letairis (LD)*				
<input type="radio"/> Opsumit (LD)*				
<input type="radio"/> Orenitram (LD)*				
<input type="radio"/> Remodulin (LD)*				
<input type="radio"/> Tracleer (LD)*				
<input type="radio"/> Tyvaso (LD)*				
<input type="radio"/> Uptravi (LD)*				
<input type="radio"/> Veletri (LD)*				
<input type="radio"/> Ventavis (LD)*				

Ancillary supplies and kits will be provided as needed for administration.

6. PRESCRIBER SIGNATURE

X	/ /	X	/ /
DISPENSE AS WRITTEN	DATE	PRODUCT SUBSTITUTION PERMITTED	DATE

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