CenterWell Specialty Pharmacy

Fax: 877-405-7940
Phone: 800-486-2668
Monday – Friday, 8 a.m.– 11 p.m., and
Saturday, 8 a.m. – 6:30 p.m., Eastern time

Pulmonary Arterial Hypertension Prescription Form

Please complete the prescription form in its entirety and fax with secure cover sheet to the number above.

Patient information

Patient: _____ ❒ Female ❒ Male DOB: _____ Height: _____ Weight: _____ ❒ lb ❒ kg Date: _____

Address: _____ City: _____ State: _____ ZIP code: _____

Home phone #: _____ Cell phone #: _____ Caregiver: _____ Caregiver phone #: _____

Other medical conditions: _____ Allergies: ❒ No ❒ Yes: _____

Insurance plan: _____ Plan ID #: _____ BIN: _____ PCN: _____ Group #: _____

*Please send a copy of the patient's prescription insurance card if available.

Clinical information

ICD-10 code:
- ❒ I27.0 primary pulmonary hypertension
- ❒ I27.2 secondary pulmonary hypertension
- ❒ _____

New York Heart Association functional classification: ❒ I ❒ II ❒ III ❒ IV

Six-minute walk distance: _____ meters

Is this patient on another therapy for pulmonary hypertension? ❒ No ❒ Yes

If "Yes," name of drug(s): _____

Attach copies of: ❒ History and physical ❒ Right heart catheterization ❒ Calcium channel blocker statement ❒ Echocardiogram

Prescription information

Note: Ohio law allows one prescription per preprinted order form. Please use additional forms for more than one prescription.

Medication

❒ Adcirca (tadalafil)
❒ Letairis (ambrisentan)
NOTE: Please complete a copy of the Ambrisentan REMS enrollment/consent form by accessing www.ambrisentanrems.us.com or calling **888-417-3172** and indicating CenterWell Specialty Pharmacy as your preferred pharmacy provider.
❒ Liqrev (sildenafil)
❒ Revatio (sildenafil)

❒ Opsumit (macitentan)
❒ Opsynvi (macitentan/tadalafil)
NOTE: Please complete a copy of the patient enrollment and consent form by accessing www.opsumitrems.com or calling **866-228-3546** and indicating CenterWell Specialty Pharmacy as your preferred pharmacy provider.

❒ Tracleer (bosentan)
NOTE: Please complete a copy of the patient enrollment form by accessing www.bosentanremsprogram.com or calling **866-359-2612** and indicating CenterWell Specialty Pharmacy as your preferred pharmacy provider.

Prescription information

Note: Ohio law allows one prescription per preprinted order form. Please use additional forms for more than one prescription.

Dose	Directions	Quantity	Refills
Initial dose:			
Maintenance dose:			
Other			

Prescriber and shipping information (please print)

Prescriber: _____ NPI: _____

Ship to: ❒ Patient ❒ Office ❒ Other: _____

Office address: _____ City: _____ State: _____ ZIP code: _____

Office phone number: _____ Office fax number: _____

Signature: _____ Date: _____

We will dispense this prescription as generic, unless the prescriber indicates "Dispense as Written" here: _____

The prescriber is to comply with his/her state-specific prescription requirements, such as e-prescribing, state-specific prescription form and fax language. Noncompliance with state-specific requirements could result in outreach to the prescriber.