MedicoRx Specialty & HOME INFUSION PHARMACY

Pulmonary Arterial Hypertension
REFERRAL FORM

Phone: 818-390-9696 Toll-free: 855-265-7850 ● Fax: 818-804-3492 Toll-free fax: 855-450-6717 ● info@MedicoRX.com

Patient information		Prescriber information	
Name:	**DOB:**	**Prescriber's Name:**	
Address: **City, State, Zip**		**NPI#**	
		DEA#	**License#**
Phone #	**Alt#**	**Address** **City, State, Zip**	
SSN:			
Height:	**Wt:**	**Phone #**	**Fax #**
Allergies:			
Emergency Contact/ Phone #		**Contact Person:**	

Clinical Consideration

Diagnosis (ICD 10) : □ I27.0 Primary pulmonary hypertension

□ **Idiopathic** □ **Familial**

□ I27.2 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/Strength	Directions for Use	Quantity	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 MedicoRX 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.

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Prescriber's signature (no stamps) if brand required check this □ DAW___ **Date**