

# PAH Referral Form



Referral Date: \_\_\_\_\_

*\*Please fax copy(s) of patient's insurance card(s) with referral*

### Patient Information

Patient Name	DOB	Sex <input type="checkbox"/> M <input type="checkbox"/> F	SSN
Address		Phone #	
City / State		Employer	
Primary Insurance		Phone #	
Name of Insured		Relationship	
Insured SS#	DOB	Employer	
Group #		Policy #	
Secondary Insurance		Phone #	
Name of Insured		Relationship	
Insured SS#	DOB	Employer	
Group #		Policy #	

May we contact the patient regarding insurance benefits and product delivery?  Yes  No

### Medical Information

**Review the following carefully & check only one of diagnosis AND treatment** (\*Note: To support these diagnoses, payors require that a history & physical be provided in addition to RIGHT heart cath with PA pressures, echocardiogram, VQ Scan/Perfusion Scan, ANA results, & trialed use of Calcium Channel Blockers)

**Diagnosis: Pulmonary Arterial Hypertension**  Familial PAH (ICD 416.0)  Idiopathic PAH (ICD 416.0)  
 (Please Check One) Associated With:  HIV (ICD\_\_\_\_)  Congenital Heart (ICD\_\_\_\_)  Scleroderma (ICD 710.1)  Other (ICD\_\_\_\_ )

Weight  lbs.  kg      Height  in  cm      Diabetic:  Yes  No

### Medication Orders

**PAH product:**  Revatio 20 mg tablet      **Dispense:**  30 Day Supply     90 day Supply  
**Sig:** Take 1 tablet po tid      **Refill:** (circle one) 0   1   2   3   4   5   6   7   8   9   10

Flolan® (continuous IV infusion)      Initial Dose: \_\_\_\_\_ ng per kg per min      dosing weight: \_\_\_\_\_ kg  
 Remodulin® (continuous subcutaneous infusion)      Concentration: \_\_\_\_\_  
 Remodulin® (continuous IV infusion)      *This is a preliminary order only for insurance clearance purposes. Patient's dose will be titrated at start of homecare.*

Please select One:  **Urgent** - Pt in Hospital     **Emergent** - Admission within 48-72 hours     **Standard** - Admission after 4 days or more

Start of Care Date (REQUIRED): \_\_\_\_\_      Tentative Discharge Date: \_\_\_\_\_

Home Nursing request to be provided by Accredo Nursing staff (Check all that apply)

Pre-Flolan/Remodulin Home Assessment / Teaching (prior to start)       In-Hospital Training (ATX)  
 Post Discharge Visit / In-Home Follow-Up       DECLINE: All Referenced Nursing       Dispense Teaching Kits

Discharge Planner - Coordinator Name \_\_\_\_\_      Fax \_\_\_\_\_      Office or Pager \_\_\_\_\_

Date \_\_\_\_\_      Time \_\_\_\_\_

*Please include a copy of the patient's insurance cards (front and back).  
 Clearance cannot be initiated until complete insurance information is provided with the patient's current history & physical.*

### Physician Information

Prescribing MD Name	Address		
License #	DEA#	NPI#	UPIN#
Phone	Fax		Office Contact Name
PCP Name (if applicable/different from prescribing MD)	Practice Specialty		Phone Number

Referral source: (please check one)  Prescribing physician     Patient self-referral     Other: \_\_\_\_\_

*\*If Nursing Services will be required for therapy administration, the home health nurse will call for additional orders per state regulations.*

**Dispense as Written:** \_\_\_\_\_      **Substitution Allowed:** \_\_\_\_\_      **Date** \_\_\_\_\_

**For questions or if you wish to submit a referral, please contact Accredo Therapeutics at**

**Phone: 1.866.FIGHT.PH    Fax: 1.800-711-3526**

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