Ascend SpecialtyRx
Simplifying Care. Achieving Outcomes.

Pulmonary Arterial Hypertension ENROLLMENT / PRESCRIPTION FORM

Customer Service Phone 1-800-850-9122 **Fax to 1-800-218-3221**

PATIENT INFORMATION

Last Name	First Name	MI	ID Number
Home Address	City	State Zip	Date of Birth / /
Shipping Address (if different from home address) ☐ Ship to MD	Home Phone Number		Work Phone Number

INSURANCE INFORMATION

(fill out entirely or fax a copy of patient's Insurance card, both sides)

Primary Insurance	**Secondary Insurance**
Policy Number	Policy Number
Group Number	Group Number

MEDICAL INFORMATION

Diagnosis: ☐ Primary Arterial Pulmonary Hypertension ☐ Secondary Arterial Pulmonary Hypertension, Secondary to ____________________

Date of Onset: _______________ Start Date of therapy: ______________ ☐ Initiation of Therapy ☐ Continuation of Therapy

Weight: ___________ ☐ lbs ☐ kg Height: __________ ☐in ☐cm Date of Measurement: _________________ ☐ See Attached

New York Heart Association(NYHA) Functional Classification: ☐ I ☐ II ☐ III ☐ IV ☐ See Attached

Mean Pulmonary Artery Pressure: _____________ Pulmonary Artery Occlusion Pressure: _______________ ☐ See Attached

Acute Pulmonary Vasoreactivity (as determined during right catheterization): _________________________ ☐ See Attached

Allergies: ____ ☐ NKDA

Current Medications: ____ ☐ See Attached

Previous Treatment: ____ ☐ See Attached

PRESCRIPTION INFORMATION

☐ **Revatio 20mg Tablet**	☐ **Other:**
☐ **Take one (20mg) tablet by mouth three times a day** ☐ **Alternate Directions:** **Quantity: _____ Refill x:_____**	☐ **Directions:** **Quantity:_____ Refill x: _____**

PRESCRIBER INFORMATION

Prescriber Name	Specialty	Office Contact	Phone Number
Address City	State	Zip	Fax Number
Today's Date / /	Date Needed By / /	DEA ☐ On File	NPI ☐ On File

I certify that the above therapy is medically necessary and all the above information is accurate to the best of my knowledge.

Prescriber's Signature

Refrigerated prescriptions are shipped Mon. - Thurs. via standard overnight service. Saturday delivery requires approval from an Ascend pharmacist. For refills, please call-in or fax 7 days in advance of next appointment.

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V.01.09