ACTELION Pathways®

VENTAVIS PATIENT ENROLLMENT FORM

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Fax To: 1-866-279-0669

PO Box 826, South San Francisco, CA 94083-0826
Phone 1-866-ACTELION (1-866-228-3546) or Fax 1-866-279-0669

Prescription

VENTAVIS® (iloprost) Inhalation Solution
2.5 mcg or 5 mcg (10 mcg/mL) inhalation via I-neb® AAD® System, as tolerated. 6 to 9 times per day during waking hours.

Start with 2.5 mcg × 1. If tolerated, go to 5 mcg (10 mcg/mL) ongoing. If not tolerated, resume 2.5 mcg.

If patient is maintained at 5 mcg (10 mcg/mL) dose and repeatedly experiences extended treatment times, consider transitioning to 5 mcg (20 mcg/mL).

☐ If patient is maintained at VENTAVIS 5 mcg (10 mcg/mL) for 1 month, consider transitioning to VENTAVIS 5 mcg (20 mcg/mL) starting at month 2, unless contacted by physician.

☐ Or please provide dosing instructions: _____

_____

Dispense 1-month supply.

Refills (select 1): 0 1 2 3 4 5 6 7 8 9 10 11

Send one (1)* I-neb AAD System if this is an initial order.

**If the patient resides in a remote area that does not allow for timely delivery (delivery within 8 hours), two (2) I-neb AAD Systems will be dispensed.*

Nursing services requested. Skilled nursing visit for patient education related to therapy and disease state, administration of medication as prescribed, and assessment of general status and response to therapy. One to 3 visits to be provided for patient training.

Patient training:

☐ Specialty pharmacy to conduct initial patient training; initial training with I-neb Insight™ breathing monitor required.

☐ PAH treatment center to conduct initial patient training; initial training with I-neb Insight breathing monitor required.

Or please provide patient training instructions: _____

Follow-up nursing visits as ordered by physician to ensure patient is proficient in medication use and I-neb AAD System administration.

☐ **Check this box to order a nursing visit to conduct an I-neb Insight download to measure patient compliance and assess patient breathing technique.**

_____ **week(s) post therapy initiation.**

Ship-to directions: ☐ Physician's office ☐ Patient's home ☐ Hospital

If shipped to physician's office, physician accepts delivery on behalf of patient for administration in office.

Address (no PO Box):	
City:	
State:	ZIP:
Ship Attn:	

I certify that the above therapy ordered is medically necessary and that the information provided is accurate to the best of my knowledge. Further, I hereby authorize Actelion Pathways® ("the Hub") to transmit this prescription to the dispensing pharmacy. PHYSICIAN SIGNATURE (REQUIRED TO VALIDATE PRESCRIPTION). Physician attests this is his/her legal signature (NO STAMPS). PRESCRIPTIONS MUST BE FAXED.

PHYSICIAN SIGNATURE (no stamps) (substitution permitted) **DATE**

PHYSICIAN SIGNATURE (no stamps) (dispense as written) **DATE**

REQUIRED: PLEASE PROVIDE COPIES OF PATIENT'S CURRENT MEDICAL INSURANCE AND PRESCRIPTION CARDS.

Specialty Pharmacy

Indicate specialty pharmacy preference:
If no preference is indicated, this referral will be sent to the appropriate specialty pharmacy based on the patient's existing insurance benefits.

☐ Benefit verification only. Do not send drug at this time.
☐ Request pre-training demonstration visit only at this time.

Physician Information

Name:		DEA #:	NPI #:
Name of facility:		MD specialty:	Tax ID #:
Contact name and phone #:		State license #:	Phone #:
Address:	City:	State: ZIP:	Fax #:

Patient Information

Name:			DOB:
Address:	City:	State:	ZIP:
Preferred language, if not English:		Phone #:	Sex: ☐ Male ☐ Female
Caregiver name:		Relationship:	Alternate phone #:

Insurance Information

Primary insurance company:			Phone #:
Policyholder name:		ID #:	Group/policy #:
Secondary insurance name:			Phone #:
Policyholder name:		ID #:	Group/policy #:
Prescription coverage name:	Phone #:	ID #:	Group/policy #:

By signing below, I authorize my healthcare providers, pharmacies, health plans, or payers ("my health care organizations") to share personal and health information about me related to my Actelion PAH therapies ("my information") with Actelion Pharmaceuticals US, Inc., its affiliates, agents, and contractors (collectively, "Actelion"). I understand that once my information is shared with Actelion, my information may be protected by certain state privacy laws but not by federal health privacy laws, and may be redisclosed by Actelion. Actelion agrees to protect my information and to use and share it only for the reasons listed below. I understand that my pharmacy may receive compensation in connection with sharing my information with Actelion as allowed under this Authorization. I authorize my health care organizations to share my information with Actelion, in order for Actelion to: (1) contact me or my healthcare organizations, or others I have identified, about my disease or treatment; (2) confirm my health plan eligibility and benefits, identify other payers for my therapy, or determine whether I may be eligible for assistance programs; (3) enroll me in Actelion PAH therapies–related programs and provide therapy access support services; (4) perform analyses or improve or develop products, services, programs, or treatment related to my disease; (5) provide me by any means of communication, including by e-mail, mail, or telephone (including voicemail), with information to educate or inform me about Actelion PAH therapies and ways to help me maintain my prescribed treatment; and (6) use and disclose my information for safety reasons or as required by law. I understand that if I do not sign this form, I will still be eligible for health plan benefits and my treatment and payment for my treatment by my healthcare providers and pharmacy will not be affected, but I will not have access to the Actelion services and support described above. This Authorization will expire 10 years from the date signed below unless a shorter period is required by the law of my state of residence. I may discuss the scope of my Authorization at any time by calling 1-866-875-0277 and may cancel it by writing a letter saying I cancel my Authorization, and mailing it to Actelion Pharmaceuticals US, Inc.: PO Box 826, South San Francisco, CA 94083. My cancellation will not be effective until after Actelion receives it and my health care organizations are notified of it by Actelion, and it will not apply to prior actions taken by Actelion and my health care organizations based on this Authorization. I have a right to request and receive a copy of this Authorization in the same ways described above for cancellation.

Patient Name (Print):	**Patient or Parent/Guardian/Representative Signature:**	**Date:**	If this form is signed by someone who is not the patient listed, describe the signer's legal authority to act for the patient: