SYNERGEN Rx Specialty Pharmacy

PAH REFERRAL FORM

Phone: 404-585-7517
Fax: 404-900-9209
NPI: 1811550528
synergenrx.com

PATIENT INFORMATION (please attach insurance card)

Name: | ☐ M ☐ F | DoB:

Street: | City: | State: | Zip:

Phone: | Phone: | Allergies:

CLINICAL INFORMATION (please attach clinical notes and labs)

Diagnosis with ICD-10 code

- ☐ **I27.0** Primary pulmonary hypertension
- ☐ **I27.21** Secondary pulmonary hypertension
- ☐ **I27.22** Pulmonary hypertension due to left heart disease
- ☐ **I27.23** Pulmonary hypertension due to lung diseases and hypoxia
- ☐ **I27.24** Chronic thromboembolic pulmonary hypertension
- ☐ Other:

Clinical History

WHO Group: ☐1 ☐2 ☐3 ☐4 ☐5

NYHA FC: ☐I ☐II ☐III ☐IV

RHC date:
mPAP ____ mmHg
PCWP ____ mmHg
PVR ____ WU

If an ERA is prescribed, please complete the following and attach documentation:

Patient REMS enrolled? ☐ yes ☐ no
Provider REMS enrolled? ☐ yes ☐ no

Date of LFTs:
AST ____ U/L ALT ____ U/L

Female patient:
☐ Reproductive – pregnancy test:
☐ Non-reproductive:

Treatment History

Current medication(s) with date(s) started:
Prior medication(s) with dates of use:

PRESCRIPTION

☐ **DAW** (deliver to ☐ patient ☐ office)

Medication	*Dose/Strength*	*Directions/Sig*	*Quantity*	*Refills*
Endothelin Receptor Antagonists (ERAs)				
☐ ambrisentan	induction ☐ 5mg	____ mg PO once daily for ____ weeks		
	maintenance ☐ 5mg ☐ 10mg	____ mg PO once daily		
☐ bosentan	induction ☐ 62.5mg	____ mg PO twice daily for 4 weeks		
	maintenance ☐ 62.5mg ☐ 125mg	____ mg PO twice daily		
Phosphodiesterase-5 (PDE5) inhibitors				
☐ sildenafil	induction ☐ 20mg tab ☐ 10mg/mL susp	____ mg PO TID for ____ weeks		
	maintenance ☐ 20mg tab ☐ 10mg/mL susp	____ mg PO TID		
☐ tadalafil	induction ☐ 20mg tab ☐ 20mg/5mL susp	____ mg PO once daily for ____ weeks		
	maintenance ☐ 20mg tab ☐ 20mg/5mL susp	____ mg PO once daily		
Other:				

To prescribe other therapies (e.g. Opsumit, Uptravi, etc.), please send the completed HUB referral form(s) or a separate prescription.

PRESCRIBER INFORMATION

Prescriber: | Supervising Physician:

Contact Name: | Contact Method: ☐ Phone ☐ Fax ☐ Email:

Phone: | Ext: | Fax:

Street: | City: | State: | Zip:

Signature: | Date: | NPI:

*By signing this form, I authorize Synergen Rx LLC and its employees to act as authorized agents on behalf of my office to obtain prior authorization through my patient's insurance plan and to facilitate the enrollment of the patient into patient assistance programs with manufacturers and other foundations.