

PAH REFERRAL FORM

PATIENT INFORMATION (please attach insurance card)

| | | | | | |
|---------|--------|----------------------------|----------------------------|--------|------|
| Name: | | <input type="checkbox"/> M | <input type="checkbox"/> 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 | | | NYHA FC | |
| <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> I | <input type="checkbox"/> II |
| | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> III | <input type="checkbox"/> 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) | | | | |
| <input type="checkbox"/> ambrisentan | induction <input type="checkbox"/> 5mg | _____ mg PO once daily for ___ weeks | | |
| | maintenance <input type="checkbox"/> 5mg <input type="checkbox"/> 10mg | _____ mg PO once daily | | |
| <input type="checkbox"/> bosentan | induction <input type="checkbox"/> 62.5mg | _____ mg PO twice daily for 4 weeks | | |
| | maintenance <input type="checkbox"/> 62.5mg <input type="checkbox"/> 125mg | _____ mg PO twice daily | | |
| Phosphodiesterase-5 (PDE5) inhibitors | | | | |
| <input type="checkbox"/> sildenafil | induction <input type="checkbox"/> 20mg tab <input type="checkbox"/> 10mg/mL susp | _____ mg PO TID for _____ weeks | | |
| | maintenance <input type="checkbox"/> 20mg tab <input type="checkbox"/> 10mg/mL susp | _____ mg PO TID | | |
| <input type="checkbox"/> tadalafil | induction <input type="checkbox"/> 20mg tab <input type="checkbox"/> 20mg/5mL susp | _____ mg PO once daily for _____ weeks | | |
| | maintenance <input type="checkbox"/> 20mg tab <input type="checkbox"/> 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: <input type="checkbox"/> Phone <input type="checkbox"/> Fax <input type="checkbox"/> 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.