

PATIENT INFORMATION

Last Name	First Name	MI	ID Number
Home Address	City	State	Zip
Date of Birth / /			
Shipping Address (if different from home address)	<input type="checkbox"/> 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

<input type="checkbox"/> Revatio 20mg Tablet	<input type="checkbox"/> Other:
<input type="checkbox"/> Take one (20mg) tablet by mouth three times a day	<input type="checkbox"/> Directions:
<input type="checkbox"/> Alternate Directions:	
Quantity: _____ Refill x: _____	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 <input type="checkbox"/> On File	NPI <input type="checkbox"/> 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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