Pulmonology Referral Form

Faxed prescriptions will only be accepted from an authorized prescriber. Prescribers are reminded patients may choose any pharmacy of their choice

1. Patient Information

Patient Name: _____ Birthdate: _____ Sex: ☐Male ☐Female Weight_____ ☐lbs. ☐kg
Preferred Phone: _____ Known Allergies_____
Address: _____ City: _____ State: _____ Zip: _____

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

2. Prescriber Information

Prescriber Name: _____ NPI#_____ Tax ID#_____
Address: _____ Phone: _____ Fax: _____
City, State, Zip: _____ Key Contact: _____

3. Diagnosis/Clinical Information

Diagnosis: _____
Does the patient have any of the following:
- ☐ Idiopathic Pulmonary Fibrosis (IPF)
- ☐ Lung CT Revealing IPF or Probable IPF
- ☐ Pulmonary Arterial Hypertension (PAH)
- ☐ Diagnosis of PAH by right heart catheterization

ICD-10: _____
Acute Vasoreactivity Test ☐ Pos ☐ Neg
WHO Functional Class (1-5): _____

Patient's History of Current Therapy
Medication(s) Dose/Duration:

Please FAX recent clinical notes, labs, and tests with the prescription to expedite the Prior Authorization

4. Prescription Information

Medication	Dose/Strength	Sig			QTY	Refills
Adcirca (Tadalafil)	☐ 40 mg Tablet	☐ Oral: 40 mg once daily				
Revatio (Sildenafil)	☐ 20 mg Tablet	☐ Oral: 20 mg 3 times daily				
Letairis (Ambrisentan) **REMS**	☐ 5 mg tablet ☐ 10 mg tablet	☐ Oral: 5 mg once daily ☐ Oral: 10 mg once daily				
Tracleer (Bosentan) **REMS**	☐ 32 mg tablet ☐ 62.5 mg tablet	Children ≥ 3 years	• 4-8 kg: oral: 16 mg twice a day • 8-16 kg: oral: 32 mg twice a day	• 16-24 kg: oral: 48 mg twice a day • 24-40 kg: oral: 64 mg twice a day		
		Adults <40 kg	• Oral: 62 mg twice a day			
		Adults ≥40 kg	• Oral: 62 mg twice a day • Oral: 125 mg twice a day			
Esbriet (Pirfenidone)	☐ 267 mg tablet ☐ 801 mg tablet ☐ 801 mg capsule	Days 1-7	☐ Oral: 267 mg 3 times daily			
		Days 8-14	☐ Oral: 534 mg 3 times daily			
		Day 15 & Beyond	☐ Oral: 801 mg 3 times daily			
OFEV®(Nintedanib)	☐ 100 mg capsule ☐ 150 mg capsule	☐ Oral: 150 mg twice a day				

Dispensing Options: ☐Patient ☐ Prescriber's Office

Prescriber Signature: Prescriber, please sign and date below

Dispense as Written Date Substitution Permitted Date

I authorize Pharmacy Representatives to act as an agent to initiate and execute the insurance prior authorization process.