

## Cardiology

Delivery N	eed By: Deliver to: 🛛 Patient	's Home 🛛 Physician's Office 🗆	Other		
PATIENT INFORMATION PRESCRIBER INFORMATION					
Address: City: Phone Number Email Address: Last Four of Sc	DOB: DOB:	1	Zip: Fax:		
INSURANCE – PLEASE FAX COPY OF PRESCRIPTION CARD FRONT & BACK					
CLINICAL INFORMATION           Diagnosis:         Has the patient been treated previously for this condition?					
			No		
	_ ft inches Weight: lbs	Medications Failed:			
Allergies:		Medications On: Other Notes:			
PRESCRIPTION INFORMATION					
Medication:	Dosage/Strength:	Directions:	Quantity: Refills:		
Adcirca	□ 20 mg tablet	<ul> <li>Take 40 mg by mouth once daily</li> <li>Other</li> </ul>	□ 30 day supply □ Other		
Ambrisentan	□ 5 mg tablet □ 10 mg tablet	<ul> <li>Take 5 mg by mouth once daily</li> <li>Take 10 mg by mouth once daily</li> <li>Other</li> </ul>	□ 30 day supply □ Other		
Bosentan	<ul> <li>62.5 mg film-coated tablet</li> <li>125 mg film-coated tablet</li> <li>32 mg tablet for oral suspension</li> </ul>	<ul> <li>Take 62.5mg by mouth twice daily</li> <li>Take 125 mg by mouth twice daily</li> <li>Other</li> </ul>	□ 30 day supply □ Other		
Entresto®	□ 24/26 mg tablet □ 49/51 mg tablet □ 97/103 mg tablet	<ul> <li>Take 24/26 mg tablet by mouth twice daily</li> <li>Take 49/51 mg tablet by mouth twice daily</li> <li>Take 97/103 mg tablet by mouth twice daily</li> <li>Other</li> </ul>	<ul> <li>□ 14 day supply</li> <li>□ 30 day</li> <li>supply</li> <li>□ Other</li> </ul>		
Praluent®	<ul> <li>Injection Single-Dose Pen 75mg/ml</li> <li>Injection Single-Dose Pen 150mg/ml</li> </ul>	□ Inject 75 mg SC every 2 weeks □ Inject 150 mg SC every 2 weeks □ Other	□ 4 Week supply □ Other		
Repatha®	<ul> <li>□ Injection Single-Dose Prefilled Syringe 140mg/ml</li> <li>□ Injection Single Dose SureClick® Auto Injector 140mg/ml</li> <li>□ Injection Single Use PushTronex™(on body infuser with prefilled cartridge) 420mg/3.5ml</li> </ul>	Pen/Syringe:Pushtronex™:□ Inject 140 mg□ Inject 420mgSC every 2SC (usingweeksdevice) once□ Other□ Other	□ 4 Week supply □ Other		
Patient is interested in patient support programs		Ancillary supplies provided	for administration		

Physician Signature:

Date: \_\_\_

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v. Q420191g



## Cardiology

Delivery Need By: Deliver to: 🛛 Patient		.'s Home 🛛 Physician's Office 🗆	] Other		
P	ATIENT INFORMATION	PRESCRIBER INF	ORMATION		
Address: City: Phone Number	□ Male □ Female □ State: Zip: □ Female □ Female □ cial: DOB:	Address:State:	Zip:		
<b>INSURANCE – PLEASE FAX COPY OF PRESCRIPTION CARD FRONT &amp; BACK</b>					
CLINICAL Diagnosis:		<b>INFORMATION</b> Has the patient been treated previously for this condition?			
ICD-10 Code:		□ Yes □ No			
		Medications Failed:			
PRESCRIPTION INFORMATION					
	PRESCRIPTI	ON INFORMATION			
Medication:	Dosage/Strength:	Directions:	Quantity: Refills:		
Medication: Revatio®			Quantity:Refills:30 daysupplyOther		
	<b>Dosage/Strength:</b> <ul> <li>20 mg tablet</li> <li>10 mg/12.5 ml vial solution for injection</li> </ul>	Directions:  Take 20 mg by mouth 3 times daily	□ 30 day supply		
Revatio® Tikosyn® Other	Dosage/Strength: 20 mg tablet 10 mg/12.5 ml vial solution for injection 10 mg/ml for oral suspension 125 mcg 250 mcg	Directions:      Take 20 mg by mouth 3 times     daily     Other	□ 30 day supply □ Other □ 30 day supply □ Other		

Physician	Signature:

Date: \_

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