benevere PHARMACY

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beneverepharmacy.com

TODAY'S DATE: ____________

☐ NEW PATIENT ☐ CURRENT PATIENT

# PULMONOLOGY REFERRAL FORM

## PATIENT INFORMATION

Patient Name ____________

Address ____________

City ____________ State ____________ Zip ____________

Home Phone ____________ Cell ____________

DOB ____________ SSN ____________

Drug Allergies ____________ ☐ Male ☐ Female

Patient Weight: ____________ Height: ____________

## PRESCRIBER INFORMATION

Prescriber Name ____________ DEA# ____________

NPI# ____________ Tax ID ____________

Medicaid ID # ____________

Address ____________ Suite ____________

City ____________ State ____________ Zip ____________

Office Phone ____________ Fax ____________

Office Contact ____________

## INSURANCE, MEDICARE OR MEDICAID INFORMATION

Primary Insurance ____________

Policy # ____________ Group ____________

Insurance Phone ____________

Secondary Insurance (if applicable) ____________

Policy # ____________ Group ____________

Insurance Phone ____________

Prescription Drug Coverage: Company ____________ Phone ____________

RXGRP# ____________ RXBIN# ____________ PCN/ID# *(if available)* ____________

COMPLETE OR FAX FRONT AND BACK COPIES OF INSURANCE AND PRESCRIPTION BENEFIT CARDS IF AVAILABLE

## CLINICAL INFORMATION

Diagnosis: ☐ Primary PAH – I27.0: ☐ Idiopathic ☐ Familial ☐ Secondary PAH – I27.2 ☐ Connective Tissue Disorder ☐ CTEPH ☐ HIV ☐ ____________

Date of Diagosis ____________ Pertinent Labs ____________

Currently on Therapy: ☐ No ☐ Yes; Drug/Duration ____________

Previous Therapies: ____________

PLEASE ATTACH A LIST OF PATIENT'S CURRENT MEDICATIONS.

| DRUG NAME | DOSE | DIRECTIONS FOR USE | QTY. | REFILLS |
|---|---|---|---|---|
| ☐ Adcirca | ☐ 20mg tablet | ☐ Take 2 tablets daily with or without food.<br>☐ ____________ | 60 | |
| ☐ Adempas | | Please fill out the Adempas Patient Enrollment form and attach | | |
| ☐ Epoprostenol Sodium | | | | |
| ☐ Flolan | | | | |
| ☐ Letairis | | Please fill out the Letairis Patient Enrollment form and attach | | |
| ☐ Opsumit | | Please fill out the Opsumit Patient Enrollment form and attach | | |
| ☐ Orenitram | | Please fill out the Orenitram Patient Enrollment form and attach | | |
| ☐ Remodulin | | Please fill out the Remodulin Patient Enrollment form and attach | | |
| ☐ Revatio | ☐ 20mg tablet<br>☐ 10mg/mL oral suspension<br>☐ 10mg/12.5 mL intravenous | Take 1 tablet three times daily. Doses should be given 4 to 6 hours apart.<br>☐ ____________ | 90 | |
| ☐ Tracleer | | Please fill out the Tracleer Patient Enrollment form and attach | | |
| ☐ Tyvaso | | Please fill out the Tyvaso Patient Enrollment form and attach | | |
| ☐ Veletri | | Please fill out the Veletri Patient Enrollment form and attach | | |
| ☐ Ventavis | | Please fill out the Ventavis Patient Enrollment form and attach | | |

☐ Patient/caregiver has received injection training/infusion details addressed ☐ Physician's office to provide injection training/infusion details addressed
☐ Pharmacy Rx to coordinate injection training/infusion details addressed

Deliver to: ☐ Patient's home ☐ MD's Office ☐ 1st dose to MD's Office, remaining refills to patient's home

By signing this form and utilizing our services, you are authorizing Benevere and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (signature required. NO STAMPS) ____________ Date ____________

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