

Ship Meds to: Patient's Home Prescriber's Office

Prescriber Information

Prescriber Name:		<input type="radio"/> MD <input type="radio"/> DO <input type="radio"/> NP <input type="radio"/> PA		NPI:
Office Contact:		Practice Name / Supervising MD:		
Address:		City:		
State:	Zip:	Phone:	Fax:	

Patient Information | PLEASE SEND COPY OF INSURANCE CARD

Patient's Name:	Last 4 Digits of SS#:	DOB: / /	Sex: <input type="radio"/> M <input type="radio"/> F	Weight:	Height:	Diabetic: <input type="radio"/> Y <input type="radio"/> N
Address:		City:	State:	Zip:	Allergies:	
Home Phone:	Work Or Cell:	HIPAA Contact:	Emergency #:	Interpreter Needed? <input type="radio"/> Y <input type="radio"/> N		

Insurance Information

Primary Insurance:	Policy ID:	Group #:	
Policyholder Name:	Policyholder DOB:	BIN:	PCN:

Clinical Information | PLEASE SEND COPY OF MEDICAL AND PRESCRIPTION INSURANCE CARDS, PROGRESS NOTES AND LAB REPORTS, SUPPORTING DIAGNOSIS, CO-MORBIDITIES AND LAB VALUES

ICD-10/Diagnosis Code:	<input type="radio"/> Primary Pulmonary Hypertension (I27.0) <input type="radio"/> Idiopathic PAH <input type="radio"/> Familial PAH		
	<input type="radio"/> Secondary Pulmonary Arterial Hypertension (I27.2) <input type="radio"/> Congenital heart disease <input type="radio"/> Connective tissue disorder <input type="radio"/> HIV <input type="radio"/> Other: _____		
Prior Treatment? <input type="radio"/> Y <input type="radio"/> N (Provide Information Below)	Approximate Start Date	Approximate End Date	
Prior Therapy	Reason for Discontinuation of Therapy		
Comorbidities:	Concomitant Medications:		

Prescription Information

Medication	Quantity/Dose	Sig	Refills
<input type="radio"/> ADCIRCA® (tadalafil)	<input type="radio"/> 20mg tablet <input type="radio"/> 30 day supply <input type="radio"/> 90 day supply	<input type="radio"/> Take 2 tablets (40mg) by mouth daily <input type="radio"/> Other: _____	
<input type="radio"/> BOSENTAN (generic Tracleer®)	<input type="radio"/> 62.5mg tablet	Starter Dose <input type="radio"/> Take 62.5mg two times a day for 4 weeks	No Refills
	<input type="radio"/> 125mg tablet <input type="radio"/> 30 day supply <input type="radio"/> 90 day supply <input type="radio"/> 62.5mg tablet <input type="radio"/> 30 day supply <input type="radio"/> 90 day supply	Maintenance Dose: <input type="radio"/> Patients >12 years old and >40kg: Take 125mg two times a day <input type="radio"/> Patients > 12 years old and <40kg: Take 62.5mg two times a day <input type="radio"/> Other: _____	
<input type="radio"/> REVATIO® (sildenafil)	<input type="radio"/> 20mg tablet <input type="radio"/> 30 day supply <input type="radio"/> 90 day supply	<input type="radio"/> Take 1 tablet by mouth three times a day <input type="radio"/> Other: _____	
	<input type="radio"/> 10mg/ml oral suspension <input type="radio"/> 30 day supply <input type="radio"/> 90 day supply	<input type="radio"/> Take 5mg (0.5ml) by mouth three times a day <input type="radio"/> Other: _____	

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

Prescriber Signature:	Date	Prescriber Signature:	Date
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Substitution Permitted

Dispense as Written

If brand is required, please write "DAW" in the box to the right.