Accredo Health Group Inc. Phone Number: 866-344-4874 **UEI: LERPSGUE3528**

VENTAVIS® (iloprost) Inhalation Solution Prescription and Statement of Medical Necessity (PSMN)

FOR VA PATIENTS ONLY

1. Forward this completed form to the VA Pharmacy for review and forwarding to Accredo Health Group Inc.
2. The VA Pharmacy will fax completed form to Accredo Health Group Inc. at 800-711-3526.

Actelion Pharmaceuticals US, Inc., our affiliates, our service providers, the Veterans Health Care Administration, your specialty pharmacy or pharmacies, and your health plans will use the information you provide to fill your prescription and to provide other services you may select.

All fields must be completed to expedite prescription fulfillment

Physician information

Name:				NPI #:
Name of facility:			MD specialty:	
Contact name:				Phone #:
Address:	Suite:	City:	State:	ZIP:

PCP (if applicable/different from prescribing MD): ______________________________

Phone #: ____________________ Fax #:

Patient information

Name:			DOB:
Address:	City:	State:	ZIP:
Preferred language (if not English):	Phone #:		Sex: ☐ Male ☐ Female
Caregiver name (if applicable):			Cell phone #:

VA Pharmacy information

Ship to: ☐ Patient ☐ VA location

Name of facility:

Address:	Suite:	City:	State:	ZIP:

Payment Method: ☐ Credit Card (call pharmacy contact) ☐ E-Invoice Tungsten Network **Purchase Order #:** ______________________

Primary purchasing contact name:	Phone #:	Fax #:	Email:
Primary clinical contact name:	Phone #:	Fax #:	Email:
Secondary purchasing contact name:	Phone #:	Fax #:	Email:
Secondary clinical contact name:	Phone #:	Fax #:	Email:

Prescription

Statement of medical necessity

I have made the determination, based on my independent clinical judgment, that the medication ordered is medically necessary for the patient for the intended use. I am personally supervising the care of this patient. I authorize Actelion Pharmaceuticals US, Inc., a Janssen Pharmaceutical Company, its affiliates, agents, and contractors to act on my behalf for the limited purposes of transmitting this prescription to the appropriate pharmacy designated by the patient utilizing their benefit plan. I certify that the patient has authorized me to share their information on this form. **PHYSICIAN SIGNATURE REQUIRED TO VALIDATE PRESCRIPTIONS. Physician attests this is his/her legal signature (NO STAMPS). Prescriptions must be faxed.**

DIAGNOSIS:

☐ **ICD-10 127.0 Primary Pulmonary Hypertension**
- ☐ Idiopathic PAH ☐ Heritable PAH
- Date of Onset ____________

☐ **ICD-10 127.21 Secondary Pulmonary Arterial Hypertension**
- ☐ Connective tissue disease ☐ Congenital heart disease with repaired shunts
- ☐ Drugs/toxins induced ☐ Other ______________________
- Date of Onset ____________

New York Heart Association (NYHA) Functional Classification ☐ III ☐ IV

Nurse Support*

☐ Please check this box if you would like your patient to receive Janssen-sponsored nurse-supported* patient education on VENTAVIS® administration. Janssen-sponsored nurse support* is available to patients who are learning to administer their VENTAVIS® therapy.

*Janssen-sponsored nurse support is limited to education for patients about their Janssen therapy, its administration, and/or their disease. It is intended to supplement a patient's understanding of their therapy, and is not intended to provide medical advice, replace a treatment plan from the patient's doctor or nurse, directly provide case management services, or serve as a reason to prescribe. Program rules and limitations will apply.

Note: Order for this drug is not inclusive of skilled nursing home health services. To request skilled nursing services for home inhalation therapy, the referring VA provider should enter a COMMUNITY CARE-GEC SKILLED HOME CARE consult. The VA facility community care office will coordinate the requested service through CCN (Community Care Network) or VCA (Veteran Care Agreement) as appropriate.

Rx

☐ **VENTAVIS® (iloprost) 10 mcg per mL/ampule 1x30 ampules**
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Equipment ☐ I-neb® AAD® Device(s)
2.5 mcg Initial Dose, Then 5.0 mcg Ongoing
Frequency ______ Times Per Day (Waking Hours)
Dispense ______ Month Supply

Ancillary Supplies Provided as Needed for Administration.

The medication cost does not include the nebulizer device and supplies. Those are provided at an additional charge.

Prescriber's Notes

Refill: ☐ PRN ☐ ______ Times In ______ Months

☐ Dispense As Written ☐ Substitution Allowed

Prescriber's Signature Date

____

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Please see full Prescribing Information for VENTAVIS®.

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