RARE SPECIALTY PHARMACY
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P: (855) 713-7049 | F: (888) 509-1154
398 W Grand Ave | Rahway, NJ 07065

Today's Date: _____
Date Needed: _____

Patient Name: _____ Date of Birth: _____/_____/_____ Gender: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Allergies/Notes: _____

(PLEASE ATTACH CLINICAL NOTES/LABS AND COPIES OF PATIENT'S INSURANCE CARDS)

Primary Insurance: _____ ID#: _____ Group#: _____ Insured's Name: _____
Employer: _____ City: _____ State: _____ Phone: _____

ICD-10 Diagnosis Code: ❑ L40.59 Psoriatic Arthritis ❑ M32.10 SLE ❑ M06.9 Rheumatoid Arthritis ❑ M45.9 Ankylosing Spondylitis ❑ M35.2 - Behcet's Disease ❑ M19.90 Osteoarthritis, unspecific site ❑ M81.0 Age-related osteoporosis w/o current fracture ❑ Other: _____
Previously treated for this condition? ❑ Yes ❑ No Medication(s) failed: _____
Patient currently taking Methotrexate? ❑ Yes ❑ No For Humira/Enbrel: PPD (TB Test) Results:_____ Date:_____ Total Swollen Joints:_____
Rheumatoid Factor Positive: _____ For Forteo: T-Score_____ Date: _____ Fracture History: Site: _____ Date: _____

PULMONARY ORDER FORM

❑**ADCIRCA**, Alyq, Tadliq 20mg tablets (generic: tadalafil)
SIG: Take _____tablets once daily
❑If applicable, *Adcirca Copay Assistance* QTY: _____ Refills:_____

❑**ADEMPAS** ❑0.5mg tablets ❑1mg tablets ❑1.5mg tablets ❑2mg tablets ❑2.5mg tablets
SIG: Take 1 tablet three times daily QTY: _____ Refills:_____
❑If applicable, enroll patient in *Aim Patient Support Program and REMS*

❑**AMBRISENTAN** ❑5mg tablets ❑10mg tablets (generic for TRACLEER)
SIG: Take 1 tablet daily QTY: _____ Refills:_____
❑If applicable, enroll patient in *LEAP Patient Support Program and REMS*

❑**BOSENTAN** ❑62.5mg tablets ❑125mg tablets (generic for LETAIRIS)
❑Initial: Take 1 tablet twice daily for ~4 weeks Patient Weight (kg):_____
❑Maintenance: Take 1 tablet twice daily
❑If applicable, enroll patient in *Bosentan REMS Program* QTY: _____ Refills:_____

❑**EPOPROSTENOL SODIUM VIAL** ❑0.5mg ❑1.5mg (generic for FLOLAN, VELETRI)
❑Initial:
❑Maintenance:
QTY: _____ Refills:_____

❑**OPSUMIT** ❑10mg tablet
❑Initial SIG:
❑Maintenance SIG:
❑If applicable, enroll patient in *PAH Companion withMe* QTY: _____ Refills:_____

❑**OPSYNVI** ❑10/20mg tablets ❑10/40mg tablets
❑Initial: 0.125mg every 8 hours to 0.25mg every 12 hours
❑Maintenance: Increase dose in increments of 0.125mg every 8 hours, or by 0.25mg or 0.5mg every 12 hours, no more frequently than every 3 to 4 days as tolerated to achieve optimal clinical response
❑If applicable, enroll patient in *PAH Companion withMe* QTY: _____ Refills:_____

❑**ORENITRAM** ❑0.125mg ❑0.25mg ❑1mg ❑2.5mg ❑5mg
❑Initial SIG:
❑Maintenance SIG:
❑If applicable, enroll patient in *Orenitram 90-Day Trial Program* QTY: _____ Refills:_____

❑**REMODULIN** ❑20mg/20mL ❑50mg/20mL ❑100mg/20mL ❑200mg/20mL injection (generic: treprostinil sodium)
❑Initial SIG:
❑Maintenance SIG:
❑If applicable, enroll patient in *Remodulin Co-Pay Assistance Program*
QTY: _____ Refills:_____

❑**REVATIO** ❑20mg tablet sildenafil citrate (generic for REVATIO)
SIG: 20mg 3 times daily. QTY: _____ Refills:_____
❑If applicable, enroll patient in *Bosentan REMS Program*

❑**TYVASO** ❑0.6mg/mL
❑Initial SIG:
❑Maintenance SIG:
❑If applicable, enroll patient in *United Therapeutics Cares Co-Pay Assistance Program*
QTY: _____ Refills:_____

❑**TYVASO DPI** ❑16mcg ❑32mcg ❑48mcg ❑64mcg ❑5mg
❑Initial SIG:
❑Maintenance SIG:
❑If applicable, enroll patient in *United Therapeutics Cares Co-Pay Assistance Program*
QTY: _____ Refills:_____

OTHER:_____ SIG:_____ QTY:____ Refills:_____

This prescription will be filled generically unless the prescriber writes "DAW" here: _____

Prescriber Name/Practice:_____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____ Office Contact: _____
License#: _____ NPI#: _____ UPIN#: _____ DEA#: _____
Prescriber's Signature (signature required, no stamps): _____Date: _____