FACTOR ONE SOURCE FAST PHARMACY
FAX 1-844-504-3278
PHONE 1-877-327-8881
www.FASTACCESSRX.com

PULMONARY ARTERIAL HYPERTENSION FORM

PATIENT INFORMATION:

Patient Name:_____
Date of Birth:_____Male:☐ Female:☐
Address:_____
City/State/Zip:_____
Tel:_____Alt Tel:_____
SS#:_____Wt:_____Ht:_____
NKDA:☐ Allergy:_____

INSURANCE INFORMATION:

Primary Pharmacy Insurance_____
Member Name:_____
Member ID:_____
Rx Group #:_____
BIN#_____PCN#_____
Customer Service #:_____
Please attach a copy of the front and back of the patient's insurance card, if available.**

DIAGNOSIS AND CLINICAL INFORMATION:

Diagnosis and ICD10: ☐ I27.0 Primary Pulmonary Hypertension
☐ Other:_____

PRESCRIBER INFORMATION:

Prescriber Name:_____Specialty:_____
Address:_____City/State/Zip:_____
Contact Name:_____Phone #:_____Fax #:_____
NPI#:_____DEA #:_____UPIN #:_____
By signing this form and using our services, you are authorizing F.A.S.T. to serve as your prior authorization designated agent in dealing with prescription and medical insurance companies.
Prescriber Printed Name:_____Date:_____
Prescriber Signature Below: (*Physician attests this is his/her legal signature.* **NO STAMPS**)

_____ _____
Substitution Allowed *Dispense as Written*

PRESCRIPTION:

Medication	Strength	Directions	Quantity	Refills
☐ Adcirca®	20mg	_____	1 month	_____
☐ Revatio®	20mg	_____	1 month	_____
☐ Other	_____	_____	_____	_____
☐ Other	_____	_____	_____	_____