VELETRI® (EPOPROSTENOL) FOR INJECTION ENROLLMENT FORM

Complete patient prescription and enrollment form

Fax to Accredo Specialty Pharmacy: 1-800-711-3526

Referral date: _____ ☐ **New patient** ☐ **Current**

Diagnosis

Check ONLY ONE box for the diagnosis related to VELETRI treatment

Pulmonary arterial hypertension (PAH) (WHO Group 1)
☐ Idiopathic PAH ☐ Heritable PAH ☐ Connective tissue disorder ☐ Congenital heart disease
☐ Other: _____

Prescription

VELETRI—continuous IV infusion administered via ambulatory pump

Dosing weight: _____ ☐ lbs ☐ kg Height: _____ ☐ in ☐ cm
☐ NKDA ☐ Known drug allergies: _____
Diabetic: ☐ Yes ☐ No Initial dose: _____ ng per kg per min
Titrate by _____ ng per kg per min every _____ days until goal of _____ ng per kg per min is reached.
Discharge dose: _____ ng per kg per min Concentration: _____ ng/mL
Dispense two (2) ambulatory infusion pumps appropriate for VELETRI if the patient does not currently have appropriate ambulatory infusion pumps.
Refills: 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐ 11☐

Ship-to directions:

☐ Patient's home ☐ VA pharmacy
Address (no PO Box):
City:
State: ZIP:
Ship Attn:

Patients should keep at least a 7-day backup supply of medication and supplies at all times.

Quantity: Dispense 1 month of drug and supplies, including pump(s)
Choose one: ☐ Sterile water for injection ☐ Sodium chloride 0.9% injection

Nursing services requested to be provided by the specialty pharmacy staff (check all that apply):
☐ In-hospital training ☐ Postdischarge visit/in-home follow-up ☐ Home assessment/training prior to initiation of therapy ☐ Dispense teaching kits
☐ DECLINE: All referenced nursing

If nursing services will be required for therapy administration, the home health nurse will call for additional orders per state regulations.

Discharge planner/coordinator name: _____

Date: _____ Time: _____ Fax #: _____ Office/page phone #: _____

I certify that I am prescribing VELETRI for this patient as a medically appropriate treatment.

Prescriber's Signature _____

Prescriber's printed name: _____ **Date:** _____

(Physician attests this is his/her legal signature. **NO STAMPS**)
This prescription is valid only if transmitted by means of a facsimile machine.

Choose one: ☐ Urgent: Patient in hospital ☐ Emergent: Admission after 48-72 hours ☐ Standard: Admission within 4+ days

Start-of-care date (REQUIRED): _____ **Tentative discharge date:** _____

Physician information

All fields must be completed to expedite prescription fulfillment.

Name:	DEA # (optional):	NPI #:
Name of facility:	MD specialty:	UPIN #:
Contact name and phone #:	State license #:	Phone #:
Address:		Suite:
City:	State: ZIP:	Fax #:
PCP (if applicable/different from prescribing MD):		Phone #:

Patient information

Name:			DOB:
Address:	City:	State:	ZIP:
Preferred language, if not English:	Phone #:		Sex: ☐ Male ☐ Female
Parent/guardian (if applicable):			Alternate phone #:

VA Pharmacy information

Name of facility:				
Address:	Suite:	City:	State:	ZIP:
Contact name:		Phone #:	Fax #:	

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