VENTAVIS® (iloprost) 20 mcg/mL MEDICATION ORDER INSTRUCTIONS

TO TRANSITION PATIENTS FROM VENTAVIS 10 mcg/mL TO VENTAVIS 20 mcg/mL:

- **BY PHONE:** Call your patient's specialty pharmacy and change your medication order

Accredo Health Group	**CVS/Caremark**
Phone: (866) 344-4874	Phone: (877) 242-2738

- **OR BY FAX:** Fill out the form below and **fax** it to your patient's specialty pharmacy

Accredo Health Group	**CVS/Caremark**
Fax: (800) 711-3526	**Fax:** (877) 943-1000

PRESCRIPTION

VENTAVIS® (iloprost) 20 mcg/mL

After current home supply is depleted, transition patient from VENTAVIS 10 mcg/mL to VENTAVIS 20 mcg/mL
6 to 9 times per day during waking hours. Dispense 1-month supply.

Dosing instructions:____

Refills (circle 1): 0 1 2 3 4 5 6 7 8 9 10 11

Prescriber signature: ____

DEA #: ________________________ **Date:** ____________________

PRESCRIBER INFORMATION

Name: ____

Name of facility: ____________________ MD specialty: ____________________

Contact name and phone #: ____

Address: ______________ City: ______________ State: ______ Zip: ______ Fax #: ______________

PATIENT INFORMATION

Name: ____________________ DOB: ____________________

Address ____________________ City ______________ State: ______ Zip: ______

Preferred language, if not English: ____________________ Phone #: ______________ Alternate phone #: ______________

Caregiver name: ____________________ Relationship: ____________________

You will be contacted by the specialty pharmacy to confirm receipt of this order.

© 2009 Actelion Pharmaceuticals US, Inc. All rights reserved. 09 180 01 00 0909