TO: Actelion Pathways®

FAX NUMBER: 1-866-279-0669

FAXED FROM: ____________________________________________________________

DATE/TIME: ____________________________________________________________

FROM: _________________________________________________________________

NUMBER OF PAGES (INCLUDING THIS ONE): __________________________________

COMMENTS: ____________________________________________________________

REQUIRED DOCUMENTATION

1) COMPLETE PATIENT ENROLLMENT
2) DOCUMENT DIAGNOSIS
3) DETERMINE CLINICAL STATUS
4) COMPLETE CCB TRIAL
5) PROVIDE REQUIRED DOCUMENTATION:  
   RIGHT HEART CATHETERIZATION, 
   ECHOCARDIOGRAM RESULTS, AND 
   HISTORY AND PHYSICAL NOTES

REMINDER: PLEASE INCLUDE PHOTOCOPY OF BOTH SIDES 
OF PATIENT INSURANCE CARD.

FAX COMPLETED FORMS TO: 1-866-279-0669
FOR MORE INFORMATION, CALL ACTELION PATHWAYS:
1-866-ACTELION  1-866-228-3546

The physician is to comply with her/his state-specific prescription requirements such 
as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance of 
state-specific requirements could result in outreach to the prescriber.

Submission of the VENTAVIS enrollment form is not a guarantee of patient approval.

Additional testing and clinical information may be requested in some cases, including:
• Antinuclear antibody results
• Pulmonary function tests
• V/Q perfusion scan
• Chest CT
**VENTAVIS PATIENT ENROLLMENT FORM**

**Fax To: 1-866-279-0669**

PO Box 826, South San Francisco, CA 94083-0826
Phone 1-866-ACTELION (1-866-228-3546) or Fax 1-866-279-0669

**Ship-to directions:**
- [ ] Physician's office
- [ ] Patient's home
- [ ] Hospital

If shipped to physician's office, physician accepts delivery on behalf of patient for administration in office.

**Address (no PO Box):**
- City: 
- State: 
- ZIP: 

**Ship Attn:**

I certify that the above therapy ordered is medically necessary and that the information provided is accurate to the best of my knowledge. Further, I hereby authorize Actelion Pathways® ("the Hub") to transmit this prescription to the dispensing pharmacy. **PHYSICIAN SIGNATURE (REQUIRED TO VALIDATE PRESCRIPTION).** Physician attests this is his/her legal signature (NO STAMPS). PRESCRIPTIONS MUST BE FAXED.

**PHYSICIAN SIGNATURE (no stamps) (substitution permitted) DATE**

**PHYSICIAN SIGNATURE (no stamps) (dispense as written) DATE**

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**REQUIRED: PLEASE PROVIDE COPIES OF PATIENT'S CURRENT MEDICAL INSURANCE AND PRESCRIPTION CARDS.**

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**Specialty pharmacy**

Indicate specialty pharmacy preference:

- [ ] Benefit verification only. Do not send drug at this time.
- [ ] Request pre-training demonstration visit only at this time.

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**Physician Information**

Name: 
Name of facility: 
MD specialty: 
Tax ID #: 
DEA #: 
NPI #: 

**Address:**
- City: 
- State: 
- ZIP: 
- Phone #: 

**Preferred language, if not English:** 
Phone #: 
Sex: [ ] Male [ ] Female

**Caregiver name:** 
Relationship: 
Alternate phone #: 

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**Insurance Information**

Primary insurance company: 
Policyholder name: 
ID #: 
Group/policy #: 

Secondary insurance name: 
Policyholder name: 
ID #: 
Group/policy #: 

Prescription coverage name: 
Phone #: 
ID #: 
Group/policy #: 

**By signing below, I authorize my healthcare providers, pharmacies, health plans, or payers ("my health care organizations") to share personal and health information about me related to my Actelion PAH therapies ("my information") with Actelion Pharmaceuticals US, Inc., its affiliates, agents, and contractors (collectively, "Actelion"). I understand that once my information is shared with Actelion, my information may be protected by certain state privacy laws but not by federal health privacy laws, and may be redisclosed by Actelion. Actelion agrees to protect my information and to use and share it only for the reasons listed below. I understand that my pharmacy may receive compensation in connection with sharing my information with Actelion as allowed under this Authorization. I authorize my health care organizations to share my information with Actelion, in order for Actelion to: (1) contact me or my healthcare organizations, or others I have identified, about my disease or treatment; (2) confirm my health plan eligibility and benefits, identify other payers for my therapy, or determine whether I may be eligible for assistance programs; (3) enroll me in Actelion PAH therapies–related programs and provide therapy access support services; (4) perform analyses or improve or develop products, services, programs, or treatment related to my disease; (5) provide me by any means of communication, including by e-mail, mail, or telephone (including facsimile), with information to educate or inform me about Actelion PAH therapies and ways to help me maintain my prescribed treatment; and (6) use and disclose my information for safety reasons or as required by law. I understand that if I do not sign this form, I will be still eligible for health plan benefits and my treatment and payment for my treatment by my healthcare providers and pharmacy will not be affected, but I will not have access to the Actelion services and support described above. This Authorization will expire 10 years from the date signed below unless a shorter period is required by the law of my state of residence. I may discuss the scope of my Authorization at any time by calling 1-866-875-0277 and may cancel it by writing a letter saying I cancel my Authorization, and mailing it to Actelion Pharmaceuticals US, Inc., PO Box 826, South San Francisco, CA 94083. My cancellation will not be effective until after Actelion receives it and my health care organizations are notified of it by Actelion, and it will not apply to prior actions taken by Actelion and my health care organizations based on this Authorization. I have a right to request and receive a copy of this Authorization in the same ways described above for cancellation.**

**Patient Name (Print):** 
Patient or Parent/Guardian/Representative Signature: 
Date: 

If this form is signed by someone who is not the patient listed, describe the signer’s legal authority to act for the patient:
It is the responsibility of the Prescriber to complete this form with information that most accurately and completely describes the condition of the patient, regardless of the potential impact on insurance coverage or reimbursement. Actelion makes no representation that the diagnosis information printed on this form is accurate or complete or that it will support insurance coverage or reimbursement.

Please select the diagnosis information that most accurately and completely describes the signs, symptoms, and condition of the patient:

**DIAGNOSIS**—THE FOLLOWING ICD-9/ICD-10 CODES DO NOT SUGGEST APPROVAL, COVERAGE, OR REIMBURSEMENT FOR SPECIFIC USES OR INDICATIONS. (CHECK THE BOX FOR THE APPROPRIATE CODE BELOW.)

- [ ] ICD-9 416.0/ICD-10 I27.0 Primary pulmonary hypertension
- [ ] ICD-9 416.8/ICD-10 I27.2 Other chronic pulmonary heart diseases
- [ ] Other: __________________________________________________________________________

**MEDICAL RATIONALE FOR OTHER**

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________
NYHA/WHO Functional Class: (Check only one)

- Class III
- Class IV
- Other:  

Clinical Signs and Symptoms: (Check all appropriate)

- Fatigue
- Shortness of breath or dyspnea on exertion
- 6-minute walk: ______ meters  Date of evaluation: ______________
- Chest pain or pressure
- Syncope or near syncope
- Edema or fluid retention
- Increasing limitation of physical activity
- Other:  

Course of Illness: (Check all appropriate)

- Evidence of worsening heart failure (eg, rales on physical exam, worsening edema, increased NT-proBNP, increased CRP)
- Worsening pulmonary hemodynamics (eg, mPAP, RAP, PVR, CO)
- Decreasing 6-minute walk test
- Change in functional class
- Worsening dyspnea on exertion
- Change in patient-reported symptoms (eg, increased fatigue)
- Other:  

Prescriber signature: ________________________________

Date: ______________
Prior to the initiation of VENTAVIS® (iloprost) Inhalation Solution, Medicare policy requires documentation that a calcium channel blocker (CCB) has been tried, failed, or considered and ruled out.¹

The above named patient was trialed as follows:

**A CCB WAS NOT TRIALED BECAUSE:**

- Patient did not meet ACCP Guidelines² for Vasodilator Response (ie, a fall in mPAP ≥10 mmHg to ≤40 mmHg, with an unchanged or increased cardiac output)
- Patient is hemodynamically unstable or has history of postural hypotension
- Patient has systemic hypotension (SBP ≤90 mmHg)
- Patient has depressed cardiac output (cardiac index ≤2.4 L/min/m²)
- Patient has known hypersensitivity
- Patient has documented bradycardia or second- or third-degree heart block
- Patient has signs of right-sided heart failure
- Other: _______________________________________________________________________________

**OR**

**THE FOLLOWING CCB WAS TRIALED:**

CCB: ________________________________________________________________________________________________

*With the following response:*

- Pulmonary arterial pressure continued to rise
- Disease continued to progress or patient remained symptomatic
- Patient hypersensitive or allergic
- Adverse event: ________________________________________________________________________________
- Patient became hemodynamically unstable
- Other: ________________________________________________________________________________

Patient: _____________________________________________________  DOB: _________________________

Physician: __________________________________________________________________________________

PLEASE CHECK EACH BOX ONCE COMPLETED.

- Right heart catheterization has been performed. Results form is attached.
  - The right heart catheterization report should include:
    - Mean pulmonary artery pressure (or systolic and diastolic pressure)
    - Cardiac output (CO)
    - Pulmonary vascular resistance (PVR)
    - Pulmonary artery wedge pressure (PAWP)

- Echocardiogram has been performed to rule out left-sided heart or valvular disease.
  Results form is attached.

- Current history and physical notes with need for therapy and PAH symptoms (e.g., dyspnea on exertion, fatigue, angina, syncope) documented. Notes are attached.

Prescriber Initials: __________ Date: __________

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**SAMPLE RIGHT HEART CATHETERIZATION RESULTS FORM**

**SAMPLE ECHOCARDIOGRAM RESULTS FORM**

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