

**Request Form for Pulmonary Arterial Hypertension Agents**  
**(iloprost [Ventavis<sup>®</sup>], bosentan [Tracleer<sup>®</sup>],**  
**ambrisentan [Letairis<sup>®</sup>], sildenafil [Revatio<sup>®</sup>])**

**Physician Information**

Name: \_\_\_\_\_

# License: \_\_\_\_\_ Physician specialty: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Patient Information**

*General Information*

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Sex:  M  F      Weight (kg): \_\_\_\_\_ Member ID: \_\_\_\_\_

Address: \_\_\_\_\_

*Medical Information*

*With the **initial prescription**, please provide the following:*

**1) Cardiac catheterization results:**

Mean pulmonary artery pressure (mmHg):

\_\_\_\_\_  Pulmonary capillary wedge pressure  
(mmHg): \_\_\_\_\_

**2) Acute vasodilator testing result (required for patients with Idiopathic Pulmonary Arterial Hypertension ONLY):**

- Positive response  
 Negative response

**3) Diagnosis according to the WHO Classification of Pulmonary Hypertension:**

- Idiopathic Pulmonary Arterial Hypertension  
 Non-idiopathic Pulmonary Arterial Hypertension -

Please specify:

\_\_\_\_\_

**4) NYHA/WHO Functional Classification:**

- I       II       III       IV

Please provide any medical information which may support approval: (optional)

Physician signature: \_\_\_\_\_

Date: \_\_\_\_\_