

VELETRI® (epoprostenol) for Injection Enrollment and Prescription Form

FOR VA PATIENTS ONLY

1. Forward this completed form to the VA Pharmacy.
2. The VA Pharmacy will fax completed form to Accredo Health Group Inc. at 800-711-3526.

Johnson & Johnson Health Care Systems Inc., our affiliates, our service providers, the Veterans Health Administration, your specialty pharmacy or pharmacies, and your health plans will use the information you provide to fill your prescription and to provide other services you may select.

Referral date: ☐ New patient ☐ Current

Diagnosis	Please select the diagnosis information that most accurately and completely describes the signs, symptoms, and condition of the patient:	
	<input type="radio"/> ICD-10 127.0 Primary Pulmonary Hypertension <input type="checkbox"/> Idiopathic PAH <input type="checkbox"/> Heritable PAH Date of Onset ____ / ____ / ____	<input type="radio"/> ICD-10 127.21 Secondary Pulmonary Arterial Hypertension <input type="checkbox"/> Connective tissue disease <input type="checkbox"/> Congenital heart disease with repaired shunts <input type="checkbox"/> Drugs/toxins induced <input type="checkbox"/> Other _____ Date of Onset ____ / ____ / ____
	New York Heart Association (NYHA) Functional Classification <input type="radio"/> III <input type="radio"/> IV	
Prescription	VELETRI®—continuous IV infusion administered via ambulatory pump	
	Dosing weight: ____ <input type="checkbox"/> lbs <input type="checkbox"/> kg Height: ____ <input type="checkbox"/> in <input type="checkbox"/> cm	
	<input type="checkbox"/> NKDA <input type="checkbox"/> Known drug allergies: _____	
	Diabetic: <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11	
	Patients should keep at least a 7-day backup supply of medicine and supplies at all times.	
	Quantity: Dispense 1 month of drug and supplies, including pump(s) Choose one: <input type="checkbox"/> Sterile water for injection <input type="checkbox"/> Sodium chloride 0.9% injection The medicine cost does not include the ambulatory pumps and supplies. Those are provided at an additional charge.	
Nurse Support* <input type="checkbox"/> Please check this box if you would like your patient to receive nurse-supported* patient education on VELETRI® mixing (reconstitution), administration, and management. Johnson & Johnson-sponsored nurse support* is available to patients who are learning to self-mix their VELETRI® therapy. *Johnson & Johnson-sponsored nurse support is limited to education for patients about their therapy by J&J, its administration, and/or their disease. It is intended to supplement a patient's understanding of their therapy, and is not intended to provide medical advice, replace a treatment plan from the patient's doctor or nurse, directly provide case management services, or serve as a reason to prescribe. Program rules and limitations will apply. Note: Order for this drug is not inclusive of skilled nursing home health services. To request skilled nursing services for home infusion therapy, the referring VA provider should enter a COMMUNITY CARE-GEC SKILLED HOME INFUSION therapy consult. The VA facility community care office will coordinate the requested service through CCN (Community Care Network) or VCA (Veterans Care Agreement) as appropriate.		
I have made the determination, based on my independent clinical judgment, that the medicine ordered is medically necessary for the patient for the intended use. I am personally supervising the care of this patient. I authorize Johnson & Johnson Health Care Systems Inc., its affiliates, agents, and contractors to act on my behalf for the limited purposes of transmitting this prescription to the appropriate pharmacy designated by the patient utilizing their benefit plan. I certify that the patient has authorized me to share their information on this form. PHYSICIAN SIGNATURE REQUIRED TO VALIDATE PRESCRIPTIONS. Physician attests this is his/her legal signature (NO STAMPS). Prescriptions must be faxed.		
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:		NPI #:	
	Name of facility:		MD specialty:	
	Contact name and phone #:		State license #:	
	Address:		Phone #:	
	City:		State:	ZIP:
	PCP (if applicable/different from prescribing MD):		Fax #:	
Patient information	Name:		DOB:	
	Address:		City:	State:
	Preferred language, if not English:		Phone #:	Sex at Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female
	Parent/guardian (if applicable):		Alternate phone #:	
VA Pharmacy information	Name of facility:			
	Address:		Suite:	City:
	State:		ZIP:	
	Payment Method: <input type="checkbox"/> Credit Card (call pharmacy contact) <input type="checkbox"/> E-Invoice Tungsten Network Purchase Order #: _____			
	Primary purchasing contact name:		Phone #:	Fax #:
	Primary clinical contact name:		Phone #:	Fax #:
	Secondary purchasing contact name:		Phone #:	Fax #:
Secondary clinical contact name:		Phone #:	Fax #:	

Please read full [Prescribing Information](#) for VELETRI®.