



REVATIO – sildenafil citrate

Member Information

Name _____
Enrollment / Cardholder ID _____
Group / Plan _____
Birth Date _____
Address _____
City State Zip _____

Relationship (Circle)

Subscriber Spouse Dependent

Gender (Circle)

Male Female

AGE: _____

Practitioner Information

Name _____
Agent / Contact Name _____
Specialty _____
Office / Clinic Name _____
Address _____
City State Zip _____
Phone () - _____
Fax () - _____
Email _____ @ _____

**Primary Diagnosis Condition /
Diagnosis Related – Reason for Request**

- Does the patient have a catheterization-proven or documented diagnosis of Pulmonary Arterial Hypertension? Y / N
- Is the patient New York Heart Association (NYHA) Functional Class II or III? Y / N
- Is the prescriber a Pulmonary Specialist or Cardiologist, or has the patient had a consult? Y / N
- Is the patient using any form of nitrates? Y / N
- Is the patient on concurrent therapy with oral erectile dysfunction medications? Y / N
- Does the patient have Retinitis Pigmentosa? Y / N

Strength / Dose

Duration of Therapy (Expected)

**Formulary Alternatives
Attempted/Outcome**

Clinical Drug / Lab History Pertinent to Request

Contact Pharmacy? Y N

Pharmacy Phone Number

Practitioner Signature

Date Received: _____
Reviewed By: _____
Forwarded To: _____

**FAX Form to
877-800-5633**