

Health New England
Medication Request Form (MRF)/Prescription Request
Flolan[®] (epoprostenol) and Remodulin[®] (treprostinil)

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Contacted:
Physician:
Pharmacy:
Patient:

Prior Authorization

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Approved:
Quantity approved:
PA from and thru date:
PA #
Denied:
Returned:

Instructions:

This form is to be used by participating physicians and pharmacy providers to obtain coverage of Flolan[®] or Remodulin[®]. Please complete this form and fax to MedMetrics Health Partners at **(800) 550-9246**. If you have any questions regarding this process, please contact MedMetrics Health Partners clinical call center at **(866)-209-1057**.

Medication Request Information (please complete each section of this form prior to transmittal):

J-Codes: Flolan J1325, unit = 0.5mg (if administered by physician only, not self administration)
 Remodulin J3285, unit = 1mg (if administered by physician only, not self administration)

Patient Information (all required)	Physician Information (all required)
Patient Name:	Physician Name:
	Specialty:
Patient Cell Phone #: () -	NPI #:
Patient HNE ID#:	HNE Provider #:
Patient Date of Birth:	DEA #:
Allergies:	Telephone #: () -
	Fax # (required): () -

Drug Information

Requested Drug/Strength/Form: <input type="checkbox"/> Flolan <input type="checkbox"/> Remodulin		
Dose, Directions, and length of treatment (please be specific):	Quantity (per month):	Refills:
Physician Signature:	Date:	

Please check or fill in all sections:

- Diagnosis is pulmonary *arterial* hypertension
- Diagnosis made by a cardiologist or pulmonologist
- Diagnosis confirmed by right-heart catheterization
- New York Heart Association Functional Status Classification I II III IV (circle one)
- Patient is NOT taking nitrates (for Revatio only)
- Patient has a failure, contraindication or intolerance to oral therapy with sildenafil
- Other pertinent information: