

## Ambrisentan Enrollment Form

FORM # (06/2024)

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To E-Prescribe Send Prescription to: WVUH Specialty Pharmacy & Home Infusion  
3040 University Ave, STE 1400 Morgantown, WV 26505

TODAY'S DATE: \_\_\_\_\_

First Name:	MI:	Last Name:		
Address:		City:	State:	Zip:
Birthdate: / /	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Preferred time to contact:	
Home Phone:	Mobile Phone:	<input type="checkbox"/> Morning (8am-12pm)		
E-mail:		<input type="checkbox"/> Afternoon (12pm-6pm)		
Alternate Contact Name:			Alternate Phone:	
Relationship:				

### PRESCRIBER INFORMATION

First Name:		Last Name:		
Title:	If NP or PA, under the direction of Dr:			
NPI #:	State License #:			
Address:		City:	State:	Zip:
Office contact and title:			Office contact phone:	
Office contact e-mail:			Office fax:	
Hours of operation:				
Office/clinic name:			Clinic/hospital affiliation:	

**\*Not required for WVU Medicine Providers**

### CLINICAL INFORMATION

Primary ICD-10 (REQUIRED):					
<b>ICD 127.0</b>		<b>CLINICAL HISTORY</b>		<b>NYHA Functional Class:</b>	
<input type="checkbox"/> Idiopathic PAH	<input type="checkbox"/> Heritable PAH	WHO Category:			
<b>ICD 127.21</b>		<input type="checkbox"/> WHO Group 1	<input type="checkbox"/> WHO Group 4	<input type="checkbox"/> Class I	<input type="checkbox"/> Class III
<input type="checkbox"/> Connective tissue disease		<input type="checkbox"/> WHO Group 2	<input type="checkbox"/> WHO Group 5	<input type="checkbox"/> Class II	<input type="checkbox"/> Class IV
<input type="checkbox"/> Congenital heart disease with repaired shunts		<input type="checkbox"/> WHO Group 3			
<input type="checkbox"/> Other (please specify):					
<b>Previous tried/failed medications:</b>		<b>Duration:</b>		<b>Reason for discontinuation:</b>	
Weight:		Height:		Date recorded: Time:	



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Current medications:

- NKDA       Known drug allergies:

### PRESCRIBER AUTHORIZATION (REQUIRED FOR ALL FEMALE PATIENTS)

Only 1 box should be checked. For female patients, please indicate the patient's current reproductive status below.

#### Female of Reproductive Potential:

Has a negative pregnancy test been confirmed prior to prescribing ambrisentan?

- Yes  
 No

OR

#### Female of Non-Reproductive Potential (choose one below):

- Pre-Pubertal Female  
 Post-Menopausal Female  
 Other medical reasons for permanent, irreversible infertility

- I certify that I have reviewed the REMS provider manual. For female patients, I have provided the appropriate counseling and REMS materials, and I will continue to fulfill my obligations under the REMS.

**REQUIRED FOR ALL  
PRESCRIBERS:**

Prescriber Signature:

Date: / /

Time:

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