VENTAVIS® (iloprost) Inhalation Solution is indicated for the treatment of pulmonary arterial hypertension (PAH) (WHO Group 1) to improve a composite endpoint consisting of exercise tolerance, symptoms (NYHA Class), and lack of deterioration. Studies establishing effectiveness included predominantly patients with NYHA Functional Class III-IV symptoms and etiologies of idiopathic or heritable PAH (65%) or PAH associated with connective tissue disease (23%).

VENTAVIS Patient Enrollment Form for VA Medical Facilities

Patient name:

IMPORTANT SAFETY INFORMATION

WARNINGS AND PRECAUTIONS

Risk of Syncope

- Vital signs should be monitored while initiating VENTAVIS. Hypotension leading to syncope has been observed; VENTAVIS should therefore not be initiated in patients with systolic blood pressure less than 85 mmHg.

Pulmonary Venous Hypertension

- Stop VENTAVIS immediately if signs of pulmonary edema occur; this may be a sign of pulmonary venous hypertension.

Bronchospasm

- VENTAVIS inhalation may cause bronchospasm and patients with a history of hyperreactive airway disease may be more sensitive.

ADVERSE REACTIONS

Serious Adverse Events

- Serious adverse events reported include congestive heart failure, chest pain, supraventricular tachycardia, dyspnea, peripheral edema, and kidney failure.

Adverse Events

- Adverse events reported in a Phase 3 clinical trial occurring with a ≥3% difference between VENTAVIS patients and placebo patients were vasodilation (flushing) (27% vs 9%), increased cough (39% vs 26%), headache (30% vs 20%), trismus (12% vs 3%), insomnia (8% vs 2%), nausea (13% vs 8%), hypotension (11% vs 6%), vomiting (7% vs 2%), alkaline phosphatase increased (6% vs 1%), flu syndrome (14% vs 10%), back pain (7% vs 3%), tongue pain (4% vs 0%), palpitations (7% vs 4%), syncope (8% vs 5%), GGT increased (6% vs 3%), muscle cramps (6% vs 3%), hemoptysis (5% vs 2%), and pneumonia (4% vs 1%).

DRUG INTERACTIONS

Antihypertensives and Vasodilators

- VENTAVIS has the potential to increase the hypotensive effect of vasodilators and antihypertensive agents.

Anticoagulants and Platelet Inhibitors

- VENTAVIS also has the potential to increase risk of bleeding, particularly in patients maintained on anticoagulants or platelet inhibitors.

Please see accompanying full Prescribing Information.

INHALED Ventavis® (iloprost) INHALATION SOLUTION

VENTAVIS® (iloprost) Inhalation Solution—Veterans Administration

SPECIALTY PHARMACY SERVICES ENROLLMENT FORM

Physician information

All fields must be completed to expedite prescription fulfillment				
Name:	DEA # (optional):			NPI #:
Name of facility:	MD specialty:			UPIN #:
Contact name and phone #:	State license #:			Phone #:
Address:	Suite:	City:	State:	ZIP:
PCP (if applicable/different from prescribing MD):_____				
Phone #:_____				Fax #:

Patient information

Name:			DOB:
Address:	City:	State:	ZIP:
Preferred language (if not English):	Phone #:		Sex: O Male O Female
Caregiver name (if applicable):			Alternate phone #:

VA pharmacy information

Name of facility:				
Address:	Suite:	City:	State:	ZIP:
Contact name:		Contact phone #:	Contact fax #:	
Ship-to address:	Suite:	City:	State:	ZIP:
Purchase order #:				
Ship to: O Patient O VA location				

Prescription

Statement of medical necessity

DIAGNOSIS:

O Primary Arterial Pulmonary Hypertension – ICD-9 416.0
Date of Onset ___ /___ /_____

O Secondary Arterial Pulmonary Hypertension – ICD-9 416.8
Date of Onset ___ /___ /_____

O Other _____ ICD-9 _____
Date of Onset ___ /___ /_____

New York Heart Association (NYHA) Functional Classification O I O II O III O IV

FAX COPIES OF MOST RECENT:

☐ History and Physical ☐ ANA Results ☐ VQ/Perfusion Scan ☐ Cardiac Catheter Report ☐ Echocardiogram
☐ Pain Management Protocol ☐ Physical Statement ☐ 6-Minute Walk Test

(Treatment with oral calcium blocking agents has been tried and failed or has been considered and ruled out)

NURSING NEEDS (check all that apply):

Start of Care Date ___ /___ /_____ Number of Visits _____ ☐ Pre-Hospital/Pre-Home Teaching ☐ In-Hospital Teaching ☐ Nursing Follow-Up

ORDERS:

Start of Care Date ___ /___ /_____ Patient Status O Urgent/Patient in Hospital O Projected Start Date ___ /___ /_____ Hospital Contact _____

Rx

☐ **VENTAVIS**
Equipment ☐ I-neb® AAD® Device(s)
2.5 mcg Initial Dose, Then 5.0 mcg Ongoing
Frequency _____ Times Per Day (Waking Hours)
Dispense _____ Month Supply
Ancillary Supplies Provided as Needed for Administration.

Prescriber's Notes

Refill: ☐ PRN ☐ _____ Times In _____ Months ☐ Dispense As Written ☐ Substitution Allowed

Prescriber's Signature Date

_____

Please provide completed form to the VA pharmacy for review and forwarding to Caremark Specialty Pharmacy.

Caremark Telephone: 1-877-242-2738 **Fax:** 1-877-943-1000

Please see accompanying full Prescribing Information.

Caremark is committed to protecting the privacy of your health information. We will hold your health information in confidence and will only use and disclose it in accordance with applicable law.