reliance|rx℠
45 Earhart Drive, Suite 110, Amherst, NY 14221

LETAIRIS AUTHORIZATION

TEL: (716) 929-1000 | 1-800-809-4763 FAX: (716) 532-7360

Last Name	First Name	Today's Date	Date Needed
Parent/Guardian		Prescriber	Hospital/Clinic
Home Phone Number ( )	Work Phone Number ( )	Phone Number ( )	Fax Number ( )
Home Address	City State Zip	Address	City State Zip
Ship To	☐ Prescriber ☐ Patient's Home	Office Contact	Prescriber Speciality
Language Preference	☐ English ☐ Spanish ☐ Other		
Known Allergies:		Contact Preference ☐ Phone ☐ Fax ☐ Email _____	
Weight _____ lbs.	Height ____ ft. ___ in.	Date of Birth ____ /____ /____	Sex ☐ M ☐ F
		Special Instructions	

INSURANCE INFORMATION

Fill out entirely or fax a copy of patient's insurance card (both sides):

Primary Insurance: _____

Name of Insured: _____

Policy #: _____

Group #: _____

Phone #: _____

Rx Drug Card #: _____

Secondary Insurance: _____

Name of Insured: _____

Policy #: _____

Group #: _____

Phone #: _____

Rx Drug Card #: _____

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: _____

ICD9 Code: _____

Is patient diagnosed with pulmonary arterial hypertension (defined as a mean pulmonary artery pressure of >25 mmHg at rest with a pulmonary capillary wedge pressure <15 mmHg)? ☐ Yes ☐ No

Is request submitted by, or under the recommendation of, a pulmonologist or cardiologist? ☐ Yes ☐ No

ALT value: _____ Date of Test: _____

AST value: _____ Date of Test: _____

Has patient tried and failed to tolerate or respond to sildenafil or tdalafil therapy (or a documented contraindication exists)? ☐ Yes ☐ No

DRUG NAME: LETAIRIS

Dose:

Frequency:

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