FUROSCIX DIRECT®

PRESCRIPTION START FORM

FUROSCIX® (furosemide injection) 80 mg/10 mL for subcutaneous use

*required

*Patient first/last name: _____ *Patient date of birth: _____

*Patient cellphone: _____ Patient other phone: _____

*Prescriber direct phone: _____ Prescriber phone extension: _____

PATIENT'S CLINICAL HISTORY

***ICD-10 code:** _____

***Condition:** ☐ HF ☐ CKD ☐ HF and CKD

Any medically verified adhesive allergy (more than a sensitivity to adhesives): ☐ No ☐ Yes

COMMERCIAL PRESCRIPTION AUTHORIZATION

MEDICATION PRESCRIBED	*INSTRUCTIONS FOR USE	*TOTAL QUANTITY OF DOSES	REFILLS
FUROSCIX 80 mg/10 mL for subcutaneous use with On-Body Infusor	☐ Administer 1 dose (80 mg) subcutaneously via the On-Body Infusor once daily as directed ☐ Administer 1 dose (80 mg) subcutaneously via the On-Body Infusor _____ for _____	# _____	No Refills Allowed

As the undersigned Prescriber, I hereby authorize and attest to the permission provided to me by the patient for the use or disclosure of the patient's health information contained in this form to other healthcare providers and relevant and necessary third-parties (including but not limited to COPILOT Provider Support Services, LLC and specialty pharmacies) their respective agents and contractors and other designees in furtherance of the patient's treatment ("Providers"), and to health plans or insurers and their respective agents and designees ("Insurers") to: (1) determine the patient's insurance benefits for FUROSCIX; (2) secure any required prior authorizations; (3) transmit the necessary information to a pharmacy that will fill the patient's prescription, and to obtain information from the pharmacy regarding delivery of such prescribed medication and related matters; (4) contact the patient to obtain any necessary signatures, consents and information relating to the patient's treatment; (5) contact the patient regarding the Patient Assistance Program, and to request information from the patient or from patient's designees needed to determine eligibility for the program; (6) to provide other related care coordination services and (7) I agree to the Business Associate Agreement as presented at www.furoscixdirect.com.

Printed first/last name of Prescriber: _____

Prescriber signature: _____ Date: _____

☑ Dispense as written

Original signature required. If this prescription form does not meet your state's requirement, please attach and fax a separate prescription or submit an electronic prescription.

***YOU MUST SELECT ONE OPTION BELOW FOR REVIEW TYPE:**

☐ Coverage & Copay Determination **ONLY**: **DO NOT CONTACT PATIENT**

☐ Expedited 24-hour Review Required: **CONTACT PATIENT**

Complete the QUICK START authorization below and sign if desired

QUICK START AUTHORIZATION

MEDICATION PRESCRIBED	INSTRUCTIONS FOR USE	TOTAL QUANTITY OF DOSES	REFILLS
FUROSCIX 80 mg/10 mL for subcutaneous use with On-Body Infusor	☑ Administer 1 dose (80 mg) subcutaneously via the On-Body Infusor daily as directed	# of authorized doses: 1 during weekdays, 2 during weekends or holidays*	No Refills Allowed

For orders checked "Expedited 24-Hour Review Required," I, the undersigned Prescriber, hereby authorize the delivery of up to 2 free doses of FUROSCIX to the patient's address for next-day delivery.

Printed first/last name of Prescriber: _____

Prescriber signature: _____ Date: _____

☑ Dispense as written

Original signature required. If this prescription form does not meet your state's requirement, please attach and fax a separate prescription or submit an electronic prescription.

**Eligible patients are authorized for up to 2 free doses for mid-week holidays.*

FUROSCIX DIRECT®

PRESCRIPTION START FORM *(continued)*

FUROSCIX® (furosemide injection) 80 mg/10 mL for subcutaneous use

*required

PATIENT INFORMATION

Healthcare prescribers can include a patient's demographic form and copy of the Rx card with the submission to help expedite the prescription.

*Patient first/last name: _____ *Date of birth: _____

*Address: _____ *City: _____ *State: _____ *ZIP: _____

*Patient cellphone: _____ Caregiver first/last name: _____ Caregiver cellphone: _____

*Language preference: ☐ English ☐ Spanish *Gender: ☐ Male ☐ Female

*Pharmacy insurance: _____ *Rx ID #: _____

*Rx group #: _____ *BIN #: _____ *PCN #: _____

*Insurance cardholder first/last name: _____ *Cardholder date of birth: _____

Patient's relationship with cardholder: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

*CURRENT AND PRIOR DIURETICS

Healthcare prescriber **MUST** include a copy of patient's most recent clinicals/discharge notes that indicate previous diuretics attempted and the outcomes along with lab results.

ORAL DIURETICS TRIED	LIST UNIT DAILY DOSE TRIED	RESULTS OF USE (EXPLAIN)
Furosemide		
Or Torsemide		
Or Bumetanide		

Lab Values: Estimated creatinine clearance _____ mL/min Estimated glomerular filtration rate (eGFR) _____ mL/min/1.73 m^2

HEALTHCARE PRESCRIBER INFORMATION

*Prescriber first/last name: _____

*Please select one: ☐ MD ☐ PA ☐ NP ☐ DO ☐ Other: _____

*Address: _____ *City: _____ *State: _____ *ZIP: _____

*Office contact: _____ *Office contact direct phone: _____

*Fax: _____ *NPI#: _____

Email address: _____ Prescriber specialty: _____

SUBMIT YOUR PRESCRIPTION

BY FAX: 1-855-616-2776

OR PRESCRIBER ORDERING SYSTEM: www.furoscixdirect.com

For questions or assistance call:

1-855-FUROSCIX

(1-855-387-6724)

Toll-Free, Monday-Friday 8AM-8PM ET