

# VYNDAQEL®/VYNDAMAX® ENROLLMENT FORM

(tafamidis meglumine or tafamidis)

Complete and fax this completed form, along with copies of both sides of the patient's insurance card[s], to 1-877-684-3116. If you have questions, please call 1-800-930-2043, Monday - Friday, 8am - 8pm CST.

## FOR PATIENTS Fields marked with \* are required.

**1 PATIENT INFORMATION**

Patient Name (First, MI, Last)\*: \_\_\_\_\_ Gender\*: Male Female  
 DOB (mm/dd/yyyy)\*: \_\_\_\_\_ Email: \_\_\_\_\_  
 Street Address\*: \_\_\_\_\_ City\*: \_\_\_\_\_ State\*: \_\_\_\_\_ Zip\*: \_\_\_\_\_  
 Primary Phone\*: \_\_\_\_\_  OK to leave message Language Preference: \_\_\_\_\_  
 Patient Caregiver Caregiver Name (First, MI, Last): \_\_\_\_\_ Caregiver Phone #: \_\_\_\_\_

**2 INSURANCE INFORMATION (Please include a copy of both sides of your insurance and prescription card[s])**

Check here if patient does not have insurance  Check here if patient has secondary insurance

Primary Insurance Name\*: \_\_\_\_\_ Primary Insurance Phone #: \_\_\_\_\_  
 Policy/Group #: \_\_\_\_\_ Primary Policyholder Name (First, MI, Last) (if other than patient)\*: \_\_\_\_\_  
 Primary Policyholder Date of Birth (mm/dd/yyyy)\*: \_\_\_\_\_ Primary Policyholder Relationship to Patient\*: \_\_\_\_\_  
 Prescription (Rx) Insurance Name\*(if applicable)\*: \_\_\_\_\_  
 Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_ Rx Bin #: \_\_\_\_\_  
*If the patient is insured through a Medicare Prescription Drug Plan, please include the full plan address\*:*

## FOR HEALTHCARE PROVIDERS Fields marked with \* are required.

**3 HEALTHCARE PROVIDER INFORMATION**

HCP Name (First, MI, Last)\*: \_\_\_\_\_ Name of Practice/Institution\*: \_\_\_\_\_ Specialty\*: \_\_\_\_\_  
 Street Address\*: \_\_\_\_\_ City\*: \_\_\_\_\_ State\*: \_\_\_\_\_ Zip\*: \_\_\_\_\_  
 Phone\*: \_\_\_\_\_ Fax #: \_\_\_\_\_ NPI #: \_\_\_\_\_ State License #: \_\_\_\_\_  
 Office Contact Name\*: \_\_\_\_\_ Office Contact Phone\*: \_\_\_\_\_ Email: \_\_\_\_\_

**4 VYNDAQEL®/VYNDAMAX® PRESCRIPTION INFORMATION**

I confirm that my patient is being prescribed VYNDAQEL/VYNDAMAX for the treatment of ATTR-CM

Primary ICD-10 Diagnosis Codes\*: \_\_\_\_\_ Secondary ICD-10 Diagnosis Codes\*: \_\_\_\_\_  
 VYNDAQEL 80 mg (four 20 mg capsules) orally once daily. Quantity: #120 capsules (30 days). Refills\*: \_\_\_\_\_  
 Alternative Dosing: VYNDAQEL (20 mg capsules): Take \_\_\_\_\_ capsules \_\_\_\_\_ times/day. Quantity: # \_\_\_\_\_ ( \_\_\_\_\_ days) Refills\*: \_\_\_\_\_  
 VYNDAMAX 61 mg (one 61 mg capsule) orally once daily. Quantity: #30 capsules (30 days). Refills\*: \_\_\_\_\_  
 Alternative Dosing: VYNDAMAX (61 mg capsules): Take \_\_\_\_\_ capsules \_\_\_\_\_ times/day. Quantity: # \_\_\_\_\_ ( \_\_\_\_\_ days) Refills\*: \_\_\_\_\_  
 Drug Allergies: No Yes (If yes, please list medication(s) and associated reaction(s)):  
 Patient's Concurrent Medications: \_\_\_\_\_

### HEALTHCARE PROVIDER SIGNATURE

Product Substitution Permitted Signature \_\_\_\_\_ Date of Signature \_\_\_\_\_ Dispense as Written Signature \_\_\_\_\_ Date of Signature \_\_\_\_\_

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to the disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by the express authority of the sender to the named addressee.