Fax: 877.684.3116 **Phone:** 800.930.2043

Orsini Specialty Pharmacy

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