Fax: 877.349.1473 **Phone:** 888.331.6574

Orsini
Rare Disease Pharmacy Solutions

ATTRUBY ENROLLMENT FORM

(acoramidis)

1 PATIENT INFORMATION (Please attach demographic 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 attach front and back of patient's insurance card, prescription card, and/or Medicaid card.)

☐ 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‡:

3 PRESCRIBER INFORMATION

HCP Name (First, MI, Last): _____ Practice Name: _____ Specialty: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax #: _____ NPI #: _____ State License #: _____

Office Contact Name: _____ Office Contact Phone: _____ Email: _____

4 PRESCRIPTION INFORMATION

ATTRUBY 356mg tablets (supplied as a carton of 112 tablets: 4 blister cards each containing 28 tablets)

☒ I confirm that my patient is being prescribed ATTRUBY for treatment of ATTR-CM (Please fax clinical documentation to pharmacy along with enrollment form)

Primary ICD-10 Code: _____ Secondary ICD-10 Code(s): _____

☐ ATTRUBY: Take 712 mg (two 356-mg tablets) orally twice daily with or without food. Quantity: 112 tablets (28 days). Refills: _____

☐ Alternative Dosing: ATTRUBY: 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: _____

_____

PRESCRIBER SIGNATURE

_____ _____ _____ _____

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