Fax: 877.349.1473 Phone: 888.331.6574

Orsini
Rare Disease Pharmacy Solutions

ATTR-CM ENROLLMENT FORM

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

Primary ICD-10 Code: ______ Secondary ICD-10 Code(s): ______
Drug Allergies: No Yes (If yes, please list medication(s) and associated reaction(s)):
Patient's Concurrent Medications: ______

______

MEDICATION	DOSE & DIRECTIONS	REFILLS
☐ ATTRUBY™ (acoramidis) (356mg tablets)	Take 712mg (two 356mg tablets) orally twice daily with or without food. Quantity: 112 tablets (28 days) Alternative Dosing: Take ___ capsules ____ times/day. Quantity: #_____ (____days)	______
☐ Vyndamax® (tafamidis) (61mg capsules)	Take 61mg (one 61mg capsule) orally once daily. Quantity: 30 capsules (30 days) Alternative Dosing: Take ___ capsules ____ times/day. Quantity: #_____ (____days)	______
☐ Vyndaqel® (tafamidis meglumine) (20mg capsules)	Take 80 mg (four 20 mg capsules) orally once daily. Quantity: 120 capsules (30 days) Alternative Dosing: Take ___ capsules ____ times/day. Quantity: #_____ (____days)	______

5 PRESCRIBER 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.

Copyright © 2025 Orsini. All Rights Reserved. SP279 - 0225