Orsini
Rare Disease Pharmacy Solutions

AMVUTTRA®	Fax: 877-349-7938	Phone: 800-372-9581
ATTRUBY™	Fax: 877-349-1473	Phone: 888-331-6574
MYQORZO™	Fax: 847- 892-1127	Phone: 847-849-1445
VYNDAMAX®	Fax: 877-684-3116	Phone: 800-930-2043

CARDIOMYOPATHY 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.)

If the patient is insured through a Medicare Prescription Drug Plan, please include the full plan address‡:

☐ 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 #: _____

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
☐ AMVUTTRA™ injection for subcutaneous use, 25mg/0.5mL	Administer Amvuttra 25mg via subcutaneous injection once every 3 months. Quantity: 1 prefilled syringe (90 days)	_____
ATTRUBY™ (acoramidis)	To prescribe ATTRUBY™ (acoramidis), please download the enrollment form from **orsini.com/attruby/**	
☐ MYQORZO™ (aficamten)	Take one ◯ 5mg ◯ 10mg ◯ 15mg ◯ 20mg tablet by mouth daily. Quantity: 30 tablets (30 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)	_____
NURSING	☐ I authorize nursing visits for RN to provide education & administer AMVUTTRA.	
SUPPLIES	☐ I authorize ancillary supplies such as alcohol wipes and a sharps container as needed to administer the AMVUTTRA therapy.	

5 PRESCRIBER SIGNATURE

_____ _____ _____ _____

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