CHIESI
CAREDIRECT

BETHKIS® 300mg 4mL (Tobramycin Inhalation Solution)

# Service Request & Prescription

Phone: 1-888-865-1222
**Fax this form to: 1-866-410-6241**
**E-mail: chiesicaredirect@caremetx.com**

## STEP 1: Complete Patient Information

Full Name (First, M.I., Last): _____

DOB: ____/____/____ Sex: ❑ Male ❑ Female

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Caregiver/Guardian: _____ Relationship: _____

Caregiver/Guardian Phone: _____

## STEP 2: Complete Insurance Information (Attach copy of insurance card-front & back)

Primary Insurance: _____

ID #: _____ Group #: _____

Subscriber's Name (if not self): _____ Employer: _____

Secondary Insurance: _____

ID #: _____ Group #: _____

Subscriber's Name (if not self): _____ Employer: _____

## STEP 3: Patient Signs Consent and HIPAA Authorization

I authorize my health plan, physician, health care professional, hospital, clinic, pharmacy or other health care provider to disclose my personal health information, including information relating to my medical condition, treatment, care management and health insurance, as well as all information provided on this form and any prescription ("Personal Health Information"), to Chiesi USA, Inc. ("Chiesi"), its affiliates and their representatives, agents and contractors for the following purposes, including investigating insurance coverage, fulfilling and coordinating delivery, assisting with product training, providing product support, providing patient support, and any internal use by Chiesi. I understand that my information disclosed under this authorization may be re-disclosed by Chiesi and no longer protected by federal or state privacy laws. I understand that I may refuse to sign this authorization, and my treating providers and health plans may not condition current or future treatment, payment or eligibility for benefits on my provision of this authorization. I understand that I am entitled to a copy of this authorization. I understand that I may cancel this Authorization at any time by mailing a letter requesting such cancellation to Chiesi CareDirect®, 6931 Arlington Rd, Suite 308, Bethesda, MD 20814, but that this cancellation will not apply to any information already used or disclosed through this authorization. This authorization expires five (5) years from the date signed below unless a shorter time is required by law. I understand that pharmacy providers may receive remuneration for disclosing my Personal Health Information pursuant to this authorization. By signing this form, I authorize Chiesi CareDirect, to send text messages to my cell phone regarding my recent treatment. I understand that standard text messaging rates will apply to any messages received from Chiesi CareDirect. I also understand that I or Chiesi CareDirect may revoke this permission in writing at any time. I agree not to hold Chiesi or Chiesi CareDirect liable for any electronic messaging charges or fees generated by this service. I further authorize pharmacy providers to use my Personal Health Information to communicate with me about the drug that has been prescribed for me and understand that they may receive a fee for such communications.

Patient's signature: _____ Date: _____

If you are signing this Authorization as a personal representative of the person to receive BETHKIS therapy, please describe authority to sign for patient (e.g. "legal guardian"): _____

Parent/Guardian/Legal Representative Signature: _____

## STEP 4: Complete Physician Information

Name: _____

Contact Name: _____

Practice Name/Institution/Department: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

State Medical Lic. #: _____ NPI #: _____

TAX ID #: _____

## STEP 5: Provide Brief Medical History

Diagnosis code: ❑ _____ ❑ Other Diagnosis: _____

Is patient transitioning from another drug? ❑ No ❑ Yes Other drug name:

## STEP 6: Complete Prescription and Statement of Medical Necessity

**Rx** ❑ **BETHKIS®** (Tobramycin Inhalation Solution)

❑ SIG: Dose: 300mg/4mL (one single-use ampule BID)

Quantity: 28 day supply Refills: _____

❑ Other SIG: _____

❑ **QuickStart** (Optional)
**Check if All Apply:** ❑ Patient is new to BETHKIS. Patient has commercial insurance (not participating in any government-funded program)
❑ **BETHKIS** (Tobramycin Inhalation Solution)
Check one: ❑ BETHKIS 14 day supply
SIG: Dose 300mg/4ml (one single-use ampule BID)

❑ **PARI LC PLUS® Reusable Nebulizer** ❑ **PARI Vios® Air Compressor**

**> If you have requested a nebulizer or air compressor,** the BETHKIS prescription request will be triaged to a Specialty Pharmacy participating in the CareDirect Nebulizer Program. Fulfillment will be based on insurance approval and program eligibility criteria. The Nebulizer Program is only available to patients covered by commercial insurance. Patients participating in federally or state-funded healthcare programs are not eligible.
**> Specialty Pharmacy Network:** BETHKIS is available through a limited specialty pharmacy network.

**Select Preferred Pharmacy (OPTIONAL):**
❑ Accredo (ESI) ❑ AllianceRX Walgreen's Prime
❑ CF Solutions ❑ CVS Caremark ❑ Diplomat Pharmacy
❑ Foundation Care ❑ IV Solutions/PSI/Maxor Specialty
❑ Optum Rx ❑ Kroger Specialty

I certify that the above therapy is medically necessary and that the information provided is accurate to the best of my knowledge. By my signature I also acknowledge that I have obtained the patient's authorization to release the above information and such other information as may be required by Chiesi and it's employees or agents to assist in obtaining coverage for BETHKIS and to assist in initiating or continuing BETHKIS therapy. I appoint CareMetx, LLC, on my behalf, to convey this prescription to the dispensing pharmacy.

Prescriber's signature: _____ Date: _____