Filsuvez® (birch triterpenes) topical gel

FILSUVEZ® Prescription Form

Please complete the entire form for each new patient. ALL fields are required. The prescription for FILSUVEZ is only valid if received via FAX at 1-877-914-0591. The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.
Call 1-833-670-6464 if you have any questions.

Chiesi TOTAL care℠

A. Prescriber Information

First Name	Last Name		Specialty		
Address			Phone	Ext.	Fax
City	State	ZIP	Office/Clinic/Institution Name		
State License #	Prescriber Tax ID		NPI #		
Primary Contact Name	Primary Contact Phone		Primary Contact Email		

B. Patient Information

First Name	M.I.	Last Name	Preferred Contact Language	
			Date of Birth / /	❍ Male ❍ Female
Allergies				❍ NKDA
Concurrent Medications:				
Parent/Guardian First & Last Name (if applicable)			Relationship	Email
Cell	Home	Work	Preferred Contact ❍ Email ❍ Phone ❍ OK to leave message	
Parent/Guardian 2 First & Last Name (if applicable)			Relationship	Email
Cell	Home	Work	Preferred Contact ❍ Email ❍ Phone ❍ OK to leave message	
Patient Address				

Prescription Insurance Information Attach copies of both sides of the patient's insurance card(s)

Primary Insurance Name			Insurance Company Phone	
Policy #			Group #	
Policy Holder Name	Date of Birth / /		Last 4 Digits of Policy Holder SSN	Pharmacy Benefit Manager
PBM Phone	RxBIN	RxPCN	RxGroup	RxID
❍ Check if patient has secondary insurance				
Secondary Insurance Name			Insurance Company Phone	
Policy #			Group #	
Policy Holder Name	Date of Birth / /		Last 4 Digits of Policy Holder SSN	Pharmacy Benefit Manager
PBM Phone	RxBIN	RxPCN	RxGroup	RxID
❍ Check if no coverage (If no coverage is determined, the patient will be considered for the Patient Assistance Program)				

C. Clinical information

ICD-10 Codes: ❍ Q81.1 Epidermolysis bullosa letalis (JEB) ❍ Q81.2 Epidermolysis bullosa dystrophica (DEB) ❍ Other _____

Patient Height _____ cm Weight _____ kg

Patient Total BSA (Body Surface Area) _____ m^2 | % BSA affected by open wounds _____

Frequency of wound dressing changes: Up to every _____ days

One tube of FILSUVEZ covers up to 250 cm^2 surface area. A tube of FILSUVEZ is for one-time use and should be discarded once opened.

D. Prescription Information

Medication	Directions	Quantity	Days Supply	Refills
❍ FILSUVEZ 10% birch triterpenes topical gel	Apply a 1mm layer of FILSUVEZ to the affected wound surface(s) at each dressing change until the wound is healed	_____ tubes	30 days	_____

Prescriber Authorization

Your signature authorizes the specialty pharmacy to dispense necessary wound care supplies associated with the application of FILSUVEZ to the skin

I authorize Chiesi and its agents as my designated agent and on behalf of my patient to (1) forward this statement of medical necessity to furnish any information on this form to and recruit necessary patient information from the insurer of above-named patient and (2) forward this prescription, by any means under applicable law, fax or other mode of delivery, to the pharmacy. I certify that the rationale for prescribing FILSUVEZ is for a primary diagnosis of EB and I will be supervising the patient's treatment accordingly.
Please select 1 option and sign only once below.

PRESCRIBER'S SIGNATURE (dispense as written). Signature stamps not acceptable. ▶ _____

PRESCRIBER'S SIGNATURE (substitution permitted). Signature stamps not acceptable. ▶ _____

DATE / /

Chiesi makes no representation that the information will comply with the requirements of any particular payer/insurer. The use of this information does not guarantee payment or that any payment received will cover your costs. Special note: The physician is to comply with their state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance of state-specific requirements could result in outreach to the prescriber.

By fax: 1-877-914-0591

Chiesi