CHIESI
CAREDIRECT

Pertzye® (pancrelipase) Delayed-Release Capsules

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 Weight _____ Height _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____ Best Time to Contact: _____

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, 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 USA, Inc. ("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 Pertzye therapy, please describe authority to sign for patient (e.g. "legal guardian"): _____

Describe Authority to Sign for the Patient: _____

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

Primary Diagnosis Code: ❑ _____ ❑ Other Diagnosis: _____

Prior Therapy Used: _____ Dates: _____

Prior Therapy Used: _____ Dates: _____

Prior Therapy Used: _____ Dates: _____

STEP 6: Complete Statement of Medical Necessity and Prescription

By signing below, I certify that (a) the below prescribed therapy is medically necessary and, (b) I have received from the patient identified above, or his/her personal representative, the necessary authorization to release, in accordance with applicable federal and state privacy laws and regulations, referenced medical and/or other patient information relating to the need for the above-prescribed therapy(ies), to Chiesi and its agents or contractors for the purpose of seeking information related to coverage for the therapy(ies) and/or assisting in initiating or continuing therapy.

Prescriber's signature: _____ Date: _____

Rx

❑ **PERTZYE®** (pancrelipase) Delayed-Release Capsules

Check one: ❑ PERTZYE 4,000 ❑ PERTZYE 8,000
❑ PERTZYE 16,000 ❑ PERTZYE 24,000

Route of Administration: ❑ P.O. ❑ G-TUBE (4,000 only)

SIG: Dose _____

Caps per day: _____ Caps per meal: _____

Caps per snack: _____

Quantity: _____

Refills: _____

Select Preferred Pharmacy (OPTIONAL): ❑ AllianceRX Walgreens Prime ❑ Foundation Care
❑ Maxor Specialty Pharmacy ❑ Fairview Specialty Pharmacy