ZYFLO connect®

FOUNDATION CARE
Your Full Service Pharmacy

Prescription Order Form

Fax to 877-291-1155

4010 Wedgeway Court
Earth City, MO 63045
Toll-Free Phone 844-MY-ZYFLO
(844-699-9356)
Toll-Free Fax 877-291-1155

PLEASE ATTACH A COPY OF INSURANCE CARD(S) (FRONT AND BACK)

PATIENT INFORMATION

Name ☐ Male ☐ Female

Street Address Date of Birth

City State ZIP

Cell Phone Number to Reach Patient Alternate Phone

Emergency Contact Phone Relationship

Allergies

Diagnosis/ICD-10 Code

PRESCRIPTION INFORMATION

MEDICATIONS	DIRECTIONS	QTY	REFILL
☐ ZYFLO CR (Zileuton) Extended-Release Tablets 600 mg*			
☐ ZYFLO (zileuton) 600 mg			

*Prescription will be filled as Zyflo CR, distributed by Chiesi USA, Inc., or as Zileuton Extended-Release Tablets, which are also available through ZYFLO connect.

PRESCRIBER INFORMATION

Signature _____ Write brand medically necessary here: _____

Name NPI #

Practice/ Facility Name Specialty

Street Address

City State ZIP

Phone Fax

DEA # SLN #

Contact Name Phone, Ext or Email

CONSENT AND HIPAA AUTHORIZATION

I authorize my health plans, physicians, 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. 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 ZYFLO connect®, 4010 Wedgeway Court Earth City, MO 63045, 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.

I understand that my pharmacy providers may receive remuneration for disclosing my Personal Health Information pursuant to this Authorization. I further authorize my 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 Signature: _____ Date: _____

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

Parent/Guardian/Legal Representative Signature: _____

04/2017 PP-MULTI-0043 V1.0

REMEMBER TO ATTACH A COPY OF INSURANCE CARD(S) (FRONT AND BACK)

Revised 04/2017