Patient Enrollment Form

Please complete and fax this form to 833.247.2756. For assistance or additional information, please call 833.695.2623, Monday – Friday, 9am – 8pm ET.

By submitting this form, I am requesting support services for Fulphila® (pegfilgrastim-jmdb) injection 6 mg/0.6 mL in a single-dose prefilled syringe, and/or Ogivri® (trastuzumab-dkst) injection 420mg, 150mg on behalf of the patient indicated below. Services include, but are not limited to: benefits verification, copay assistance, prior authorization assistance and assistance with appeals.
***required field**

☐ **Check if requesting Copay Assistance Program only**

PATIENT INFORMATION

First Name* ______ Middle Initial ___ Last Name* ______

DOB (MM/DD/YYYY)* ______ Gender M ☐ F ☐ Email ______

Address* ______ City* ______ State* ______ Zip* ______

Primary Phone Number ______ Secondary Phone Number ______ Language ______

OK to Contact Patient for Additional Information? YES ☐ NO ☐

Alternate Contact Name ______ Relationship ______ Phone Number ______

INSURANCE INFORMATION

☐ Check if patient does not have insurance

Primary Insurance Name* ______ Insurance Phone* ______

Policy #* ______ Group #* ______

Policyholder Name ______ Relationship to Patient ______

Secondary Insurance Name* ______ Insurance Phone* ______

Policy #* ______ Group #* ______

Policyholder Name ______ Relationship To Patient ______

PRESCRIBER INFORMATION

First Name* ______ Last Name* ______

Tax ID # ______ NPI #* ______ Group NPI # ______

Payer Specific Provider # ______

Practice Name* ______

Address* ______ City* ______ State* ______ Zip* ______

Practice Phone Number* ______ Practice Fax Number* ______

Primary Contact Name* ______ Primary Contact Email* ______

MEDICATION AND CLINICAL INFORMATION** (Check the medication(s) the patient has been prescribed)

Product: **FULPHILA®** (pegfilgrastim-jmdb)	Product: **OGIVRI®** (trastuzumab-dkst)
Primary Diagnosis (ICD-10)* ______	Primary Diagnosis (ICD-10)* ______
Secondary Diagnosis ______	Secondary Diagnosis ______
Site Of Care* ______	Site Of Care* ______

PRESCRIBER CERTIFICATION:

By completing and transmitting this form, I am certifying that I have received from my patient and have on file the patient's HIPAA consent and all other necessary permissions from my patient authorizing the release of the patient's identification and insurance information, including the information I have provided above, to VIATRIS™ Inc. (d/b/a VIATRIS ADVOCATE®), its affiliates, its program administrator, and their respective agents and service providers (collectively, "Viatris Advocate") for them to use in providing the patient with benefit verification and support services as described herein.

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