The Medicines Company

ORBACTIV® Support Programs
PO Box 4280
Gaithersburg, MD 20855-4280

ORBACTIV® (oritavancin) Support Programs
PHYSICIAN REQUEST FORM

Phone: 1.844.ORBACTIV **Fax:** 1.855.886.2482
Hours: Monday through Friday, 8:00 a.m. – 8:00 p.m. ET

SERVICE(S) REQUESTED		
Check all that apply:	☐ Insurance Verification ☐ Copay Savings Program *(eff. Sept 2015)*	☐ Prior-Authorization Assistance ☐Patient Assistance Program (PAP)

PRESCRIBER & SHIPMENT INFORMATION (Stock replacement requests will be shipped to the address below)			
Contact Name:	Contact Phone #:	Contact Email:	
Physician Name:		Specialty:	
Facility Name:			
Address:			
City:	State:	Zip Code:	
Phone #:	Fax #:		
Physician Tax ID #:	Physician NPI #:	DEA #:	
Facility Tax ID #:	Facility NPI #:		
State License #:	Issuing State:	Expiration Date:	

PATIENT INFORMATION (required)		
US Resident: ☐Yes ☐No	SSN/ID #:	
Patient Name:	Phone #:	
Gender: ☐M ☐F	Date of Birth:	
Address:		
City:	State:	Zip Code:

INSURANCE INFORMATION (attach a copy of insurance cards, if available) ☐ CHECK IF UNINSURED	
Primary Insurance:	Secondary Insurance:
Insurance Phone #:	Insurance Phone #:
Policy #:	Policy #:
Group #:	Group #:
Policy Holder's Name:	Policy Holder's Name:
Policy Holder's DOB:	Policy Holder's DOB:

TREATMENT INFORMATION (required)		
Setting of Care: ☐ Hospital Inpatient	☐ Hospital Outpatient ☐ Physician Office	Date of Service:
☐ Home Infusion	☐ Other – Please specify:	ICD-10 Code:

FINANCIAL INFORMATION (only complete if applying for Patient Assistance)	
Total Annual Household Income**: $	Household Size (include patient):
Income documentation attached (1040, 1040EZ, W2, SSI Ltr, SSDI, Bank Statements, etc.) ☐Yes ☐No	
**Proof of household income is required for eligibility into this PAP. Attach income documentation to this form. THE MEDICINES COMPANY reserves the right to request additional documentation if necessary to confirm eligibility.	

Certification and Consent (required)

I certify to the best of my ability that the information above is accurate and complete regarding insurance information and financial need. I have received consent from the patient or the patient's guardian to enroll the patient in THE MEDICINES COMPANY Or ORBACTIV® PAP and I agree to allow THE MEDICINES COMPANY, or an authorized representative, to review the medical, financial and insurance records for this patient at any time for the purpose of verifying the patient's eligibility status. I also attest that I have secured the patient's or the patient's guardian's written permission, to the extent and in the form required by law, to disclose the data to THE MEDICINES COMPANY's authorized representative. I further represent that this patient has no medical or prescription insurance coverage for the applied for drug, including all public programs. My signature certifies that no other submissions for payment for product(s) provided under the program will be made to any private, federal or state healthcare program or the patient.

Physician: I have read and agree to the terms detailed on this form.

X _____ Date: _____

Physician's original signature (no stamped signatures)

The Medicines Company

ORBACTIV® Support Programs
PO Box 4280
Gaithersburg, MD 20855-4280

ORBACTIV® (oritavancin) Support Programs
PHYSICIAN REQUEST FORM

Phone: 1.844.ORBACTIV **Fax:** 1.855.886.2482
Hours: Monday through Friday, 8:00 a.m. – 8:00 p.m. ET

COPAY SAVINGS PROGRAM INFORMATION
PAYMENT PREFERENCE

Select one: ☐ Check ☐ Electronic Payment

PRESCRIBER BILLING INFORMATION (Payment for copay requests will be sent to the address below)

Same as facility address: ☐ Yes ☐ No

Contact Name:	Contact Phone #:	Contact Email:
Billing Address:		
City:	State:	Zip Code:
Phone #:	Fax #:	

COPAY SAVINGS PROGRAM DISCLAIMER

Patients must be United States residents and be 18 years of age or older. Eligible patients must have a minimum of a $50 copayment or coinsurance obligation for ORBACTIV® (oritavancin) for Injection. The Program will cover up to $350 of a patient's obligation, and the patient must contribute $50 toward their copay or coinsurance. The Program does not cover deductible, premium, or other amounts that are not explicitly identified as copayment or coinsurance. Patients who pay cash or who are enrolled in or participate in any type of government insurance or reimbursement programs, including but not limited to Medicare, Medicaid, including managed Medicaid, Tricare, and FEHP, are not eligible. As a condition precedent of the copayment or coinsurance support provided under this program, e.g., copay or coinsurance amounts paid to administering providers, participating patients and administering providers are obligated to inform insurance companies and third-party payors of any benefits they receive and the value of this program, as required by contract or otherwise. Void where prohibited by law, taxed, or restricted. Additional terms and conditions may apply. Patients enrolled in the ORBACTIV® Patient Assistance Program are not eligible. The Medicines Company may determine eligibility, monitor participation, and modify or discontinue any aspect of this Program at any time. For additional information regarding ORBACTIV®, including Important Safety Information, please see the Full Prescribing Information available at www.orbactiv.com.