

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

ORBACTIV[®] (oritavancin) Support Programs PHYSICIAN REQUEST FORM

Check all that apply: □ Insurance Verification □ Copay Savings Program (eff. Sept 2015) □ Patient Assistance Program (PAP) PRESCRIBER & SHIPMENT INFORMATION (Stock replacement requests will be shipped to the address below) Contact Name: Contact Name: Specialty: Facility Name: Address: Specialty: Facility Name: Zip Code: Phone #: Zip Code: Phone #: Specialty: Physician Tax ID #: Fax #: Physician NET #: DEA #: Facility Tax ID #: Fax #: Physician Tax ID #: Fax #: Physician Tax ID #: Fax #: Physician NET #: Expiration Date: Patient Name: Expiration Date: Patient Name: SN/ID #: Expiration Date: Patient Name: □ Date of Birth: □	SERVICE(S) REQUESTED								
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ORBACTIV[®] Support Programs PO Box 4280 Gaithersburg, MD 20855-4280

ORBACTIV® (oritavancin) Support Programs PHYSICIAN REQUEST FORM

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:	Contac	ct Phone #:	Contact Email:					
Billing Address:								
City:		State:	Zip Code:					
Phone #:		Fax #:						
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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.

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