PRIALT (ZICONOTIDE) INTRATHECAL INFUSION | NAVIGATOR Reimbursement and Access Program®

PRIALT® (ziconotide) intrathecal infusion
Patient Enrollment Form

1-855-PRIALT1 (774-2581) • Fax: 1-855-PRIALT3 (774-2583) • www.navigatorprogram.com

PATIENT INFORMATION

Patient Name:	☐ Male ☐ Female	Date of Birth:
Address:	Home Phone #:	Alternate #:
	Email:	
City/State/ZIP:	Diagnosis Code/Medical Information (required):	

INSURANCE VERIFICATION REQUESTED

☐ Yes (Please complete insurance information below. Results will be provided to the prescribing physician.)
☐ No (Insurance information not required. Patient or physician will not receive information regarding financial assistance options.)

INSURANCE INFORMATION *(PLEASE COPY AND ATTACH FRONT AND BACK OF INSURANCE AND PRESCRIPTION DRUG CARD.)* FOR TERTIARY PAYOR PLEASE COMPLETE ADDITIONAL FORM.

Medical Insurance:	Policy Holder:	Referral #:	SSN:
Group #:	Policy #:	Phone #:	
Secondary Insurance:	Policy Holder:	Phone #:	
Group/PCN #:	Policy #:	RxBIN #:	
Workers' Comp Claim: ☐ Yes ☐ No	Date of Injury:		

PRESCRIPTION INFORMATION - Required for both BioScrip and Alternative Pharmacy Fulfillment

Drug(s)	Daily Dose (mcg/d)	Final Concentration (mcg/mL or mg/mL)	Infusion Rate - Specify Units (mL/hr or mL/d)	Refill Frequency/Date (No refills permitted for Schedule II drugs)
PRIALT® (ziconotide) intrathecal infusion ***NOTE: Maximum PRIALT dose 19.2 mcg/d (0.8 mcg/hr)*** ☐ 25 mcg/mL (20 mL vial) ☐ 100 mcg/mL (1 mL vial) ☐ 100 mcg/mL (5 mL vial)				

☐ **Prepare total of _____mL of the above drug(s) in a syringe for instillation into pump reservoir. (BioScrip Fulfillment Only)**

☐ **Provide whole PRIALT vials as appropriate to fill above prescription.**

SITE OF ADMINISTRATION - Required for both BioScrip and Alternative Pharmacy Fulfillment

☐ **Physician's Office** ☐ **Hospital Outpatient** ☐ **ASC** ☐ **Other (please explain)** _____

Facility Name:	Clinical Contact:	
Address:	City/State/ZIP:	
Site Contact:	Site Phone #:	Needed Date:

MUST SELECT EITHER BIOSCRIP OR ALTERNATIVE PHARMACY FULFILLMENT

☐ **BioScrip Pharmacy Fulfillment**
Shipping Information: ☐ Check if shipping address is same as site of administration address above.

Facility Name:	Clinical Contact:	
Address:	City/State/ZIP:	
Site Contact:	Site Phone #:	Needed Date:

☐ **Alternative Pharmacy Fulfillment - Must be a currently state licensed pharmacy to receive product**
Shipping Information:

Facility Name:	Facility Contact (to coordinate shipping):
Address:	City/State/ZIP:
Site Phone #:	Needed Date:

NOTICE for Alternative Pharmacy Fulfillment: To fulfill the Rx as written above, the calculated number of PRIALT whole vials will be confirmed and shipped to the Alternative Pharmacy.

PHYSICIAN CONTACT INFORMATION & CONSENT/AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Physician Last Name:		Phone #:	Ext:	Fax #:
First Name:	Middle Initial:	DEA #:	Office Contact:	Facility Name:

By signing this form, you are certifying that the described therapy above is medically necessary and within the approved indication, and you have received written consent to release the above referenced medical and/or other patient information to NAVIGATOR.

DISPENSE AS WRITTEN	**DATE:**	**PRODUCT SUBSTITUTION PERMITTED**	**DATE:**

(Stamped signatures and co-signed signatures cannot be filled by a pharmacy per law.)

Please see full Prescribing Information, including BOXED Warning, for important safety information.

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PATIENT CONSENT/AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name:_____

I hereby authorize my doctor(s) and their staff, my health insurer(s) and the specialty pharmacy or distributor that will supply PRIALT and/or fill my prescription (the "Pharmacy") to disclose my personal information, including but not limited to, information about my medical condition and treatment (including prescriptions), health insurance, social security number and related information ("Personal Information") to Jazz Pharmaceuticals, its business partners and agents, including the Pharmacy (together "Jazz Pharmaceuticals"), to help implement the NAVIGATOR Reimbursement and Access Program® described to me by my doctor (the "Program"). I understand that my Personal Information will be used by Jazz Pharmaceuticals to (i) help to verify, investigate or coordinate insurance coverage and payment for PRIALT; (ii) coordinate my receipt of, and payment for PRIALT; (iii) enroll me in and contact me about the Program; (iv) provide education, information, products, programs and services; (v) permit Jazz Pharmaceuticals to manage the Program, and conduct market analyses or other commercial activity, including aggregating my Personal Information with other data; and (vi) assist with analysis related to quality, efficacy and safety for PRIALT. I understand that Jazz Pharmaceuticals, through the Program or the Pharmacy, may report back to my doctor(s) any Personal Information about me that they may create or receive. I agree that Jazz Pharmaceuticals may contact me in the future via email, mail, telephone or otherwise. I understand that once my health information is disclosed it may no longer be protected by federal or state law regarding patient privacy and it may be subject to re-disclosure without my permission; however, Jazz Pharmaceuticals agrees to use and disclose my Personal Information only for the purposes described in this Authorization or as required by law. I understand that I may refuse to sign this authorization or revoke it at any time in the future, and my refusal or future revocation will not affect my treatment, payment or eligibility for benefits. Revoking this authorization will not affect Jazz Pharmaceuticals' ability to use and disclose Personal Information it has already received. This authorization will remain valid for ten (10) years after the date of my signature, unless I revoke it earlier by calling 1-855-PRIALT1. I also understand that the Program may be changed or ended at any time without prior notification and that I will receive a copy of this authorization.

Patient/Guardian Signature:_____ **Date:**_____

Please see full Prescribing Information, including BOXED Warning, for important safety information.