ThyrogenONE®
Ordering and Reimbursement Support

Please FAX Form to: 1.888.326.1002 Phone: 1.88.THYROGEN (1.888.497.6436) www.thyrogen.com

Prescription Support Form for Thyrogen® (thyrotropin alfa for injection)

SECTION I: Services Requested (select one)

£ Benefit Verification & Co-Pay Assistance Determination £ Benefit Verification & Specialty Pharmacy Triage & Co-Pay Assistance Determination

SECTION II: Patient Information

First Name:	Middle Initial:	Last Name:	DOB:
Address:			
City:	State:	Zip Code:	
£ OK to leave message	Home Phone #:	Cell/Work #:	

SECTION III: HIPAA Consent (select one)

STOP Do you have the patient's HIPAA consent on file? £ Yes £ No

- ThyrogenONE® must confirm that your office has a written HIPAA consent on file to conduct benefit verification services.

SECTION IV: Insurance Information £ INSURANCE CARDS ATTACHED £ NO INSURANCE

Primary Insurance Name:	**Subscriber Name:**	**DOB:**
Policy #:	Group #:	Phone #:
Prescription Drug Card:	Group #:	Phone #:
Secondary Insurance Name:	**Subscriber Name:**	
Policy #:	Group #:	Phone #:
Prescription Drug Card:	Group #:	Phone #:

SECTION V: Prescriber Information

Prescriber Specialty: £ Endocrinology £ Nuclear Medicine £ Surgery £ Other _____

Prescriber First Name:		Prescriber Last Name:		ThyrogenONE® ID #:	
State License #:	NPI #:	Tax ID #:	DEA #:	BCBS Provider #:	
Practice Name:		Phone #:		Fax #:	
Practice Address:		City:		State:	Zip Code:

Site of Administration: £ Physician Office £ Hospital Outpatient £ Infusion Center

Reimbursement/Clinical Contact Name:	Title/Role:
Phone #:	Email:
Shipping Address (if different from Practice Address listed above):	
City:	State: Zip Code:
Shipping Contact Name (if different from Reimbursement Contact listed above):	Phone #:

SECTION VI: Prescription Information

Rx Thyrogen® (thyrotropin alfa for injection) 1.1 mg vial, packaged 2 vials per kit. SIG - Administer 0.9 mg IM (intramuscular)

£ ICD-10 Diagnosis Code: C73 £ ICD-9 Diagnosis Code: 193 £ Other: _____	Dosage & Administration: £ Q 24 HR x 2 Doses £ Supplies Needed: _____	Procedure Type: £ Radioiodine Ablation £ Follow Up Testing: £ First £ Subsequent	First Thyrogen Injection Date:

If I have requested specialty pharmacy triage, I authorize ThyrogenONE® to forward the above prescription information to the most cost-effective specialty pharmacy in order to dispense Thyrogen to the above named patient. If there are multiple options at the same cost to the patient, I understand that ThyrogenONE® will contact me to select which specialty pharmacy to contact. I understand that State law may require the pharmacy to contact me directly.

PRESCRIBER'S SIGNATURE:	**Date:**

Reminder: This form cannot be processed without the prescriber's signature, the prescriber's acknowledgement of the patient's HIPAA consent, and copies of patient insurance card(s) (if available).

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Please complete all fields in each section. This will help expedite the processing of referral.

- **Section I: SERVICES REQUESTED** - Please indicate the type of service requested.

  - **Benefit Verification & Co-Pay Assistance Determination:**

  ThyrogenONE will:
  - Complete benefit investigation and report results back to physician.
  - Determine if patient is eligible for copay assistance and report decision back to physician.
  - If eligible, enroll patient in copay program and notify physician, patient and billing entity.
  - If not eligible, notify physician and patient.

  - **Benefit Verification & Co-Pay Determination & Specialty Pharmacy Triage:**

  ThyrogenONE will:
  - Complete benefit investigation and report results back to physician
  - Triage request to appropriate Specialty Pharmacy to dispense medication.
  - Determine if patient is eligible for copay assistance and report decision back to physician.
  - If eligible, enroll patient in copay program and notify physician, patient and billing entity.
  - If not eligible, notify physician and patient.

- **Section II: PATIENT INFORMATION**
  - Write legibly and complete all fields to prevent processing delays

- **Section III: HIPAA CONSENT**
  - The provider **must** indicate that there is a patient consent on file

- **Section IV: INSURANCE INFORMATION**
  - Include both primary & secondary insurance so that all potential coverage is explored.
  - Include all sources of insurance coverage, including Medicare & Medicaid (if applicable).
  - Provide clear and legible copies of both sides of the insurance & prescription drug cards.

- **Section V: PRESCRIBER INFORMATION**
  - Please indicate the provider Tax ID, NPI, DEA, and State License numbers.
  - Remember to include shipping address if it's different from the practice address.

- **Section VI: PRESCRIPTION INFORMATION**
  - If requesting Specialty Pharmacy triage, be sure to check the correct dosage.
  - Prescriber signature is required.
  - Due to storage requirements of Thyrogen, make sure it is refrigerated upon receipt.

Please FAX Form to: 1.888.326.1002

REMINDER: The Patient Enrollment Form cannot be processed without the prescriber's signature, the prescriber's acknowledgement of patient's HIPAA consent and copies of the patient's insurance card(s).

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