fensolvi totalsolutions™

Please FAX Form to: 1-412-520-3442
Phone: 1-866-FENSOLVI (1-866-336-7658)
Monday – Friday, 8 AM – 8 PM ET

fensolvi® (leuprolide acetate) for injectable suspension

Fensolvi Patient Enrollment Form

1. Patient Information

PATIENT NAME (LAST, FIRST)	SEX ☐ Male ☐ Female	DOB
ADDRESS 1	ADDRESS 2	
CITY	STATE	ZIP
PARENT/CAREGIVER NAME (LAST, FIRST)		
PARENT EMAIL	PARENT PHONE #	

2. Insurance Information ☐ INSURANCE CARDS ATTACHED ☐ NO INSURANCE

PRIMARY INSURANCE NAME		SECONDARY INSURANCE NAME	
SUBSCRIBER NAME	DOB	SUBSCRIBER NAME	DOB
RELATIONSHIP	MEMBER #	RELATIONSHIP	MEMBER #
GROUP #	PHONE #	GROUP #	PHONE #
PRESCRIPTION DRUG CARD	MEMBER #	PRESCRIPTION DRUG CARD	MEMBER #
GROUP #	PHONE #	GROUP #	PHONE #

3. Service Requested

☐ **Specialty Pharmacy Fulfillment** (choose additional services)
☐ PA Assistance ☐ Copay Enrollment
Preference ☐ No Preference ☐ Kroger ☐ Maxor ☐ CVS/Caremark

☐ **Buy and Bill Benefit Verification only** (choose additional services)
☐ PA Assistance ☐ Copay Enrollment
☐ Specialty Pharmacy Triage when Buy & Bill not available

☐ **Patient Assistance Program**

4. Prescriber Information

PRESCRIBER NAME (LAST, FIRST)			PRACTICE NAME	
ADDRESS 1			ADDRESS 2	
CITY	STATE	ZIP	PHONE #	FAX #

DESIGNATION	STATE LICENSE #	NPI #	TAX ID #	PTAN #	PROVIDER #
REIMBURSEMENT/CLINICAL CONTACT NAME					PHONE #

Site of care: ☐ Hospital/Outpatient ☐ Ambulatory/Surgical Center ☐ Physician's Office ☐ Other:

SHIPPING ADDRESS 1 (IF DIFFERENT FROM ABOVE)	ADDRESS 2	
CITY	STATE	ZIP
SHIPPING CONTACT NAME	PHONE #	

OVER ▶

Fensolvi Patient Enrollment Form

fensolvi® (leuprolide acetate) for injectable suspension

5. Prescription Information – Fensolvi 45 mg kit

☐ ICD-10/Diagnosis Code: E30.1
☐ ICD-10/Diagnosis Code: E22.8
☐ Other:

DIRECTIONS AND ROUTE
Inject 45 mg subcutaneously every 6 months by a healthcare professional

QUANTITY: 1 REFILLS: 0 ☐ 1 ☐

CPT CODE

KNOWN ALLERGIES

OTHER CONDITIONS

By signing below, I verify that I am a practicing healthcare provider, authorized to request, prescribe and receive prescription medications at the address identified herein. I certify that the therapy prescribed is medically necessary and verify that the information provided is complete and accurate to the best of my knowledge. I further certify that (a) any reimbursement investigation service provided through Tolmar Pharmaceuticals, Inc. and its agents is not made in exchange for any express or implied agreement or understanding that I would recommend, prescribe, or use the above therapy or any other product or service for or from anyone, and (b) my decision to prescribe the above therapy was based solely on my determination of medical necessity as set forth herein. I also attest that I have obtained all appropriate patient authorizations and consents, including a signed HIPAA authorization, to disclose the patient's protected health information, and such other information as may be required, to Tolmar Pharmaceuticals, Inc. and its agents, to use and disclose as may be necessary to assist in obtaining coverage for the product, initiating therapy, providing treatment support services, and administering the Fensolvi® programs. I affirm that the patient has been informed and agrees that (1) information disclosed pursuant to the patient's authorization may no longer be protected by federal or state privacy law and may be redisclosed, and (2) authorization is voluntary and refusal to consent will not affect the patient's ability to obtain treatment or insurance benefits. I authorize Tolmar Pharmaceuticals, Inc. and its agents, and the dispensing pharmacy, to share information about the patient on my behalf, to convey this prescription to the pharmacy for dispensing, and for the pharmacy to dispense per its customary and usual procedures. I agree that I shall not bill, sell, seek reimbursement from the government or any third party or file any claim for the drug product provided by Tolmar TotalSolutions or other Hub offering.

PRESCRIBER SIGNATURE

DATE

For Ohio Licensed Healthcare Practitioners Only

Please print/type your Terminal Distributor of Dangerous Drug (TDDD) license number (if applicable): _____

Please visit the Ohio State Board of Pharmacy website (www.pharmacy.ohio.gov) for additional information on when a prescriber must hold a TDDD license.

Are you exempt from TDDD licensure? ☐ Yes ☐ No

By checking "Yes," you attest that you meet one of the licensing exemptions under ORC 4729.541. Exemptions include but are not limited to: (1) prescribers who are sole proprietors; (2) business practices with a sole shareholder (per Ohio law, group practices with multiple shareholders are not exempt); and (3) dentists licensed by the Ohio Dental Board. Please visit the Ohio State Board of Pharmacy website for additional information. By checking "No," you attest that you have provided a valid TDDD license number above. Your signature serves as attestation and that you have the appropriate TDDD licensure or qualify under an exemption.

Patient Consent

By signing this form, I authorize my physician, pharmacies, and other healthcare providers ("Healthcare Providers") and my health insurers to share my health information with Tolmar Pharmaceuticals, Inc. and its agents, including, but not limited to, reimbursement hub vendors, pharmacies, and data aggregators (collectively, "Tolmar"). I understand that my health information includes information relating to my medical condition, treatment, and insurance coverage, as well as identifying information about me (including, for example, my name, address, and date of birth). My health information will be shared with Tolmar so that Tolmar may provide me with various support and information to help me access Fensolvi, which may include the following:

1. provide certain services to me, including reimbursement and coverage support, patient assistance and access programs
2. determine my ongoing eligibility status and future transfers, withdrawals or cancellations, including case reviews, audits, assessments and other verification procedures
3. provide me with support services and information associated with Fensolvi
4. serve internal business purposes, such as marketing research, internal financial reporting and operational purposes, and
5. carry out Tolmar's respective legal responsibilities.

I understand that signing this authorization is voluntary and that my healthcare providers will not condition my treatment on my agreement to sign this authorization, and my health insurer will not condition payment for my treatment, insurance enrollment or eligibility for insurance benefits on my agreement to sign this authorization. I understand that I am entitled to receive a copy of this authorization after I sign it.

Once my health information has been disclosed to Tolmar, I understand that it may be redisclosed by them and no longer protected by federal and state privacy laws. However, Tolmar agrees to protect my health information by using and disclosing it only for the purposes detailed in this authorization or as permitted or required by law. I understand that pharmacies may receive remuneration from Tolmar in exchange for my health information or other support services.

This authorization will remain in effect for a period of ten (10) years or until I revoke my authorization, unless required to be shorter by state law. I may revoke this authorization at any time by mailing a letter to Fensolvi TotalSolutions, 6000 Park Lane, Pittsburgh, PA 15275. Revoking this authorization will end further disclosure of my health information to Tolmar by my healthcare providers and health insurers when they receive a copy of the revocation, but it will not apply to information they have already disclosed to Tolmar based on this authorization. If my insurance information changes in any material respect (e.g. change in insurance provider), I agree to promptly notify Tolmar. I agree that I will not seek reimbursement from the government or any third party or file any claim for the drug product provided by Tolmar TotalSolutions or other Hub offerings.

PRINT PATIENT NAME

If you are signing this Authorization as a personal representative of the person to receive Fensolvi, please state your relationship (e.g., "mother," "father," "Legal Guardian")

PRINT NAME OF CAREGIVER/LEGAL REPRESENTATIVE

RELATIONSHIP TO PATIENT

SIGNATURE

DATE

tolmar