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 ▶

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5. Prescription Information

☐ ICD-10/Diagnosis Code: E30.1 ☐ ICD-10/Diagnosis Code: E22.8 ☐ Other:	DIRECTIONS & ROUTE Inject 45 mg subcutaneously every 6 months by a healthcare professional QUANTITY: 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. ("Tolmar") 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 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) I, applicable pharmacies, and other health care providers, as well as the patient's health insurers, may share the patient's health information with Tolmar and its agents, including, but not limited to, reimbursement hub vendors, pharmacies, and data aggregators, pursuant to the HIPAA patient authorization, (2) Tolmar and its agents may provide the patient with various support and information to help the patient access Fensolvi and may contact the patient by email, telephone, voicemail, or text to do so, (3) Tolmar and its agents may use the patient's information for internal business purposes (such as marketing research, financial reporting, operations, and fulfillment of legal responsibilities), and (4) authorization is voluntary, may be revoked at any time by the patient once given, and refusal to consent will not affect the patient's ability to obtain treatment or insurance benefits.

I authorize Tolmar 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.

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