

# Vyndaqel Enrollment Form

Complete and fax this completed form, along with copies of both sides of the patient's insurance cards, to 1-877-684-3116. If you have questions, please call 1-800-930-2043, Monday-Friday, 8 AM-8 PM CST.

**For Patients** Fields marked with \* are required.

<b>1. Patient Information</b>			
Name (First, MI, Last)*			Gender* <input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth (mm/dd/yyyy)*		Email	
Street Address*			
City*		State*	ZIP Code*
Primary Phone*		<input type="checkbox"/> OK to leave message	Language Preference
<input type="checkbox"/> Patient Caregiver	Caregiver Name		Caregiver Phone

<b>2. Insurance Information</b> (Please include a copy of both sides of your insurance and prescription card[s])			
<input type="checkbox"/> Check here if patient does <b>not</b> have insurance <input type="checkbox"/> Check here if patient has secondary insurance			
Primary Insurance Name*			
Primary Insurance Phone Number*		Policy/Group #*	
Primary Policyholder Name (First, MI, Last) (if other than patient)*			
Primary Policyholder Date of Birth (mm/dd/yyyy)*		Primary Policyholder Relationship to Patient	
Prescription (Rx) Insurance Name*(if applicable)			
Policy #*	Group #*	Rx Bin #*	
If the patient is insured through a Medicare Prescription Drug Plan, please include the full plan address <sup>‡</sup> :			

**For Healthcare Providers** Fields marked with \* are required.

<b>3. Healthcare Provider Information</b>			
HCP Name (First, MI, Last)*		Practice/Institution Name*	Specialty*
Street Address*			
City*		State*	ZIP Code*
Phone*	Fax*	NPI #*	State License #*
Office Contact Name*	Office Contact Phone*		Email

<b>4. VYNDAQEL® (tafamidis meglumine) Prescription Information</b>			
Patient Name (First, MI, Last)*		Patient Date of Birth (mm/dd/yyyy)*	<input type="checkbox"/> I confirm that my patient is being prescribed VYNDAQEL for the treatment of ATTR-CM
<input type="checkbox"/> I attest that my patient's diagnosis was confirmed.		Please list type of diagnostic test:	
Primary ICD-10 Diagnosis Code*		Secondary ICD-10 Diagnosis Code	
Dose* <input type="checkbox"/> VYNDAQEL 80 mg (four 20-mg tafamidis meglumine capsules) orally once daily, Quantity #120 capsules (30 days)			Refills*
Drug Allergies: <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, please list medication(s) and associated reaction(s)):			
Patient's Concurrent Medications:			
Other Known Conditions:			

## HEALTHCARE PROVIDER SIGNATURE

Product Substitution Permitted Signature \_\_\_\_\_ Date of Signature \_\_\_\_\_ Dispense as Written Signature \_\_\_\_\_ Date of Signature \_\_\_\_\_

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