VISTOGARD®
(uridine triacetate) oral granules

Prescription Referral Form

To ensure your patient receives his/her medication as soon as possible please complete, sign and fax this form to

BioMatrix Specialty Pharmacy

Phone: 844.374.0604 | Fax: 844.374.0605

Patient Information		Gender: ☐ Male ☐ Female
First Name:	MI:	Last Name:
DOB:	Email:	
Primary Contact Number: ( )		Alternative Number: ( )
Alternate Contact Number: ( )		
Address:		
City:	State:	Zip Code:
Diagnosis: ICD-10 Code: ☐ 5-FU/Capecitabine Toxicity _____ ☐ Other _____		
Reason for Vistogard Need: ☐ 5-FU Overdose ☐Capecitabine Overdose ☐ Early-onset, severe or life-threatening toxicities ☐ Other		
Chemotherapy Regimen:	Site of Primary Tumor:	Cycle of Regimen:
Allergies:	**Weight:**	**Height:** **BSA:**
Current Medications Taken by Patient:		

Insurance Information	
Prescription Insurance Provider:	
Policy ID #:	Rx Group #:
Rx BIN:	RX PCN:
Note: You may include a copy of the front and back of the patient's primary and secondary prescription drug insurance cards. Complete the Patient Assistance Program (PAP) Application to determine eligibility in the event the patient requires assistance.	

Prescription for VISTOGARD® (uridine triacetate) 10 gram packets

Quantity: ☐ Full Course of Therapy (**Carton Includes**: 20 single-dose packets for 5 Days)
☐ 24-Hour Pack (**Carton Includes**: 4 single-dose packets) Total Days Needed: _____

Directions: ☐ Adults: 10 grams (1 packet) orally every 6 hours for 20 doses, without regard to meals
☐ Other Directions:

Start Date:

Preferred Shipping Location: ☐ Patient Address	☐ Prescriber's Address	☐ Alternate Address
Alternate Shipping Address:		
City:	State:	Zip Code:
Prescriber Information		
Prescriber Name:		NPI #:
Office Address:		
Office Phone #:	Office Fax #:	Office Contact:

X Prescriber Signature _____ **Date:** _____

Dispense as Written

VISTOGARD®
(uridine triacetate) oral granules

PATIENT ASSISTANCE PROGRAM (PAP) APPLICATION

Annual Gross Household Income: $ Number of Household Members:

Are you a citizen or legal resident of the United States? ☐ Yes ☐ No

Patient Acknowledgement (for Patient Assistance Program application only)

I understand that completing this form does not ensure that I will qualify for the Vistogard® Patient Assistance Program ("PAP"). I represent that the information provided in this enrollment form is complete and accurate. I agree to notify and shall be responsible for notifying the program administrator for the PAP if I obtain coverage through another source or if I no longer meet the income criteria for the PAP. I understand that BTG reserves the right at any time and without notice to me to modify and/or discontinue any or all of the PAP, including modification of eligibility criteria and immediate termination of assistance provided by the PAP. I understand that I may decline to sign this form and decline being considered for the PAP.

X Patient Signature: **Printed Name:** **Date:**

X Legal Representative Signature: **Printed Name:** **Date:**

If signed by legal representative, describe the nature of his/her relationship with the patient:

Patient Authorization to Release, Collect, Use and Disclose Medical Information

If patient has not previously provided authorization, please have patient review the following Authorization:

Vistogard's Specialty Pharmacy provider can provide certain services to you and on your behalf during the search for Vistogard therapy reimbursement and support services, including hospital discharge coordination and financial assistance services. The Vistogard Specialty provider is operated by BioMatrix Specialty Pharmacy, a contractor of BTG and the exclusive distributor of Vistogard. In order to provide these services, the Vistogard Specialty Pharmacy provider will need to use health information about you that it obtains from your health plan, healthcare providers (which may include physicians and hospitals), and the pharmacy that will receive your doctor's prescription (this information is called "Protected Health Information" or "PHI") to do so. This Authorization will allow your healthcare providers, health plans, and health insurers that maintain PHI about you to disclose your PHI to the Vistogard Specialty Pharmacy so that the Vistogard Specialty Pharmacy provider may provide these services to you or on your behalf. I understand that as part of its function as a potential pharmacy providing healthcare services to me, the Vistogard Specialty Pharmacy provider may use my PHI to perform the following services: (a) to establish my eligibility for benefits; and (b) to communicate with my healthcare providers and me about my medical care; and (c) to share my PHI back to BTG.

By signing this Authorization, I authorize my physician, hospitals, health plans, and pharmacy providers to disclose my PHI, including information relating to my medical condition, treatment, care management, and health insurance, as well as all information provided on this form and any prescription to the Vistogard Specialty Pharmacy provider and its representatives, agents, and contractors for the following purposes: (1) to facilitate the provision of products related to Vistogard, supplies, or services to me by a third party including, but not limited to, specialty pharmacies and copay assistance; (2) to register me in any applicable registration program required for my treatment; and (3) to communicate with my healthcare providers and me about Vistogard. I understand that disclosures of my PHI pursuant to this Authorization may no longer be protected by federal privacy law and may be re-disclosed. I understand that I may refuse to sign this Authorization and that my treatment, payment for treatment, enrollment, or eligibility for benefits is not conditioned on my signing this Authorization. I understand that I am entitled to a copy of this Authorization after I sign it. I understand that I may inspect or otherwise receive copies of any PHI disclosed to others pursuant to items (1) through (3) above, and I may be charged a reasonable fee for the cost of such copies. I understand that I may cancel this Authorization at any time by mailing a letter requesting such cancellation to the Vistogard Specialty Pharmacy, 3070 McCann Farm Dr. #101, Garnet Valley, PA 19060 but that this cancellation will not apply to any information already used or disclosed through this Authorization. This Authorization expires one (1) year from the date signed below.

I understand and agree that my physician, hospitals, health plans, pharmacy providers, and other entities may receive direct or indirect remuneration from BTG in exchange for disclosing identified data described herein to BTG and/or for providing me with therapy support, information regarding products, or other services subsidized by BTG.

X Patient Signature: **Printed Name:** **Date:**

X Legal Representative Signature: **Printed Name:** **Date:**

If signed by legal representative, describe the nature of his/her relationship with the patient: