VISTOGARD® Prescription Referral Form

Fax: 844.374.0605 Phone: 844.374.0604

VISTOGARD® (uridine triacetate) oral granules

INSTRUCTIONS: To ensure your patient receives his/her medication as soon as possible please complete, sign and fax this form to Biologics Specialty Pharmacy (844.374.0605).

☐ Check here if VISTOGARD® will be dispensed in an office/clinic or hospital pharmacy instead of through Biologics Specialty Pharmacy.

1 CASE MANAGEMENT INFORMATION

It is important to enroll patients receiving Vistogard® in the case management program as soon as possible to avoid potential disruptions in treatment. For optimal case management services, please include hospital case manager or primary contact information for discharge coordination.

Name_____ Title_____

Phone_____ Email_____ Preferred Contact Method: ☐ Phone ☐ Email

2 PATIENT INFORMATION

Please attach additional contact information if necessary. Due to pharmacy regulations, the dispensing pharmacy must contact the patient or their caregiver in order to offer counseling.

Full Name_____ Gender ☐ M ☐ F DOB_____ Social Security #_____

Patient Address_____ City_____ State_____ Zip_____

Primary Phone_____ Alternate Phone_____

Alternate Contact_____ Relationship_____ Phone_____

3 INSURANCE INFORMATION

Please include a copy of the front and back of the patient's primary and secondary prescription drug insurance cards.

Please complete the Patient Assistance Program (PAP) Application in Section 7 to determine eligibility in the event the patient requires assistance.

4 CLINICAL INFORMATION

Primary Diagnosis/Stage_____ ICD9/10 code for 5-FU/capecitabine_____

Reason for Vistogard need (5-FU/capecitabine related): ☐ Overdose ☐ Early-onset, severe or life-threatening toxicities

☐ Other_____ ICD9/10 code for reason for Vistogard need_____

Treatment plan prior to overdose_____

Describe overdose and/or side effects_____

_____

Last dose of 5-FU/capecitabine administered_____ Date_____ Time_____

Height_____ Weight_____ Allergies_____

List other medications that the patient is currently taking (including any other chemotherapy) _____

_____

5 PRESCRIBER INFORMATION

Prescriber Name_____ DEA#_____ NPI#_____

Hospital/Clinic_____

Phone_____ Fax_____ Tax ID_____

Address_____ City_____ State_____ Zip_____

6 PRESCRIPTION INFORMATION

VISTOGARD® (uridine triacetate) 10 gram packets Quantity: ☐ 4 ☐ 8 ☐ 12 ☐ 16 ☐ 20 ☐ Other_____

Start Date_____ Number of outpatient treatment days_____

Directions_____

Preferred Shipping Location ☐ Prescriber's Address (as listed above) ☐ Patient's Address (as listed above) ☐ Alternate Address

Street_____ City_____ State_____ Zip_____

X Prescriber Signature_____ **Date**_____

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7 PATIENT ASSISTANCE PROGRAM (PAP) APPLICATION

Annual Gross Household Income $_____ Number of Household Members (including patient)_____

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

Patient Acknowledgment (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 International Inc. 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_____

8 REQUIRED: Prescriber Authorization

By signing below, I certify that I have obtained a valid authorization from the patient listed on this form (or such patient's legal representative), authorizing me to release the patient's Protected Health Information to the Vistogard Specialty Pharmacy Provider as necessary to obtain insurance coverage for Vistogard® and other adjunct therapies and to enroll in financial assistance programs for Vistogard®.

X Prescriber Signature _____ **Date** _____

9 REQUIRED: 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 Biologics, Inc., a contractor of BTG International Inc., a BTG International group company and the exclusive distributor of Vistogard; however, no BTG International group company will have access to patient-specific health information. 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.

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 my PHI disclosed under items (1) through (3) of this Authorization may no longer be protected by federal privacy law and may be re-disclosed by the Vistogard Specialty Pharmacy provider. 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 , 120 Weston Oaks Court, Cary, NC 27513, but that this cancellation will not apply to any information already used or disclosed through this Authorization by my healthcare providers and health plans before they learned of my cancellation. 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 International Inc. in exchange for disclosing de-identified data described herein to BTG International Inc. and/or for providing me with therapy support, information regarding products, or other services subsidized by BTG International Inc.

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_____

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