

1. Service(s) Requested

- Insurance verification & assistance program eligibility assessment
Insurance verification only
Other (please specify)

2. Patient Information

Name, Birth date, Sex, Address, City, State, Zip, Primary contact, Relationship, Home phone #, Work phone #, Mobile phone #, Preferred phone number: Home, Work, Mobile

3. Insurance Information

Primary insurance, Card holder name, ID #, Group#, BIN #, PCN#, Secondary insurance, Card holder name, ID #, Group#, BIN #, PCN#

4. Diagnosis and Clinical Information (please check all that apply)

- Cystic fibrosis (277.0), Cystic fibrosis with gastrointestinal manifestations (277.03), Exocrine pancreatic insufficiency (577.8), Other, please specify: Chronic pancreatitis (577.1), Patient using pancreatic enzymes? Yes, No, If Yes, what type?

Notes:

5. ZENPEP Prescription Dose

Dispense as written, Refills, 5000 USP lipase units, 10,000 USP lipase units, 15,000 USP lipase units, 20,000 USP lipase units, SIG/Directions

6. Delivery Location and Pharmacy Preference

- Preferred delivery location: Patient's home (listed above), Other, please indicate:

Site name, Address, City, State, Zip code, Phone #, Fax #

Intended for patient use.

**7. Prescriber and Patient Advocate Information**

Prescriber name		Title	Office/Clinic/Institution	
Address		City	State	Zip code
Phone #		Alternate phone #	Fax #	
State lic.#	DEA#	NPI#	Group tax ID#	
Patient advocate name		Title	Office/Clinic/Institution	
Address		City	State	Zip Code
Phone #		Alternate phone #	Fax #	
State lic.#	DEA#	NPI#	Group tax ID#	

A Patient Advocate may be a health care worker involved in the patient’s care – a nurse, social worker, or care manager. Friends or family members cannot act as Patient Advocates.

By signing below, I certify that (1) the above therapy is medically necessary, (2) I have received the appropriate permission from the patient and met any other applicable requirements imposed under the Health Insurance Portability and Accountability Act of 1996 and/or state law needed to release the above information to Eurand and contractors designated by Eurand for the purposes of verifying the patient’s insurance coverage for Zenpep™ (pancrelipase) Delayed-Release Capsules; seeking prior authorization for ZENPEP, if needed, on my patient’s behalf; providing information on appeals of denials of claims; coordinating delivery of ZENPEP to my patient’s preferred site; and providing me and my patient with other educational and support services associated with ZENPEP, (3) I will not sell or bill any free product received in my office, and (4) I authorize the above prescription to be forwarded to the pharmacy chosen by the named patient.

Prescriber signature (no stamps)

Date

**Patient Certification**

I verify that the information provided in this application is complete and accurate. I understand that Eurand and its agents (together, “Eurand”) may request documentation to verify financial or insurance information, and that any assistance in the form of free medication is contingent upon meeting the program eligibility criteria. I also understand that Eurand reserves the right at any time, and without notice, to modify the application form, modify or discontinue this program and its eligibility criteria, or terminate assistance.

Patient or Legal guardian/Personal representative signature \_\_\_\_\_

Patient Authorization for Use and Disclosure of Individually Identifiable Health Information \_\_\_\_\_

I authorize my health care providers and health plans to disclose information about me (for example, my name, social security number, mailing address, and insurance information), and my medical condition (including information about my CF status as all such information is my “health information”) to Eurand and I authorize Eurand and its agents to use and disclose my health information to: 1) establish my benefit eligibility; 2) provide support services, including facilitating the provision of ZENPEP; 3) to contact me to evaluate therapy and the effectiveness of the program; and 4) to ensure the accuracy and completeness of this application.

I understand that once my health information has been disclosed to Eurand, federal privacy law will no longer restrict its use or disclosure, however state law may provide some protection and Eurand agrees to use and disclose my health information only for the purposes described above or as required by law. I further understand that I may refuse to sign this authorization and that if I refuse, my eligibility for health plan benefits and treatment by my health care providers will not change, but I will not have access to the services available through this program. I may cancel this authorization at any time by notifying Eurand in writing and submitting it by fax to 1-888-832-5335. If I cancel, I will no longer have access to the services available through this program, and Eurand will stop using or disclosing my health information for the purposes listed above, except as required by law or as necessary for the orderly termination of my participation in the program. This authorization will expire 10 (ten) years from the date it is signed by me. I am entitled to a copy of this signed form.

Patient advocate name		Title	Office/Clinic/Institution	
Address		City	State	Zip Code
Phone #		Alternate phone #	Fax #	

I, the patient or legal guardian, authorize the following individual(s) to act as my representative(s). These individual(s) have my full permission to obtain and disclose personal and medical information about me to Eurand and its agents and contractors (“Eurand”).

Name of representative	Home phone #	Mobile phone#
Representative’s relationship to patient		
Name of representative	Home phone #	Mobile phone#
Representative’s relationship to patient		