FastAccess Prescription Order & Patient Support Program (for Free Clinic)

FastAccess | Exeltis Rethinking healthcare

Eagle Pharmacy Contact Information:
Phone: (877)-303-7181 · Fax: (877)-620-2849

FastAccess Program ("Program") Confidential Application Form

Eagle Pharmacy has been retained by Exeltis to review Program applications and determine if patients have available resources to purchase prescribed medication. For patients without insurance and are presumed indigent, Benznidazole Tablets shall be provided at no charge from Exeltis' Patient Assistance Plan (PAP).

The physician must fill out Section 1 through 6 below, and sign where indicated.

1. Physician Information

Physician Name: _____ Site/Facility Name: _____

Street Address: _____ City: _____ State: ____ Zip: _____

Office Contact: _____ Telephone: _____ Best time to call: _____

Fax: _____ NPI # _____

2. Prescription

Upon approval for assistance through the Program, medication will be shipped via Eagle Pharmacy.

Product Name: Benznidazole Tablets
Strength (check one): ☐ 100 mg ☐ 12.5 mg

Directions: _____

Quantity: _____ Refill(s): _____ DAW: 1

☐ Check box if prescription to be sent via eRx: Eagle Pharmacy
Lakeland, FL 33810
NPI# 1487905840
NABP# 5711975

Prescription only valid for US patients. Prescription only valid for one fill.

3. Patient Clinical Information

Patient Diagnosis/ICD-10 Code: B57. _____ Weight: _____

Other Health Conditions: ☐ No known _____

Allergies: ☐ No known _____

Medications and Supplements: ☐ No known _____

4. Shipping Information:

Address: _____

City: _____ State: _____ Zip Code: _____

5. Patient Information:

Patient Name: _____ Date of Birth: _____ Gender: ☐ male ☐ female ☐ n/a

Guardian Name: _____ Primary Language: _____

Phone Number: _____ Best time to call: _____

Email Address: _____

6. Physician Declaration

I certify that the above therapy is medically necessary, and that the information provided is accurate, to the best of my knowledge.

I certify that I am the prescriber who has prescribed Benznidazole Tablets to the above-named patient and that I provided the patient with the full Prescribing Information for Benznidazole Tablets. I authorize Exeltis and its affiliates, agents, representatives, and service providers to: (1) forward this prescription to a dispensing pharmacy that will dispense the medication to the above-named patient; (2) process this FastAccess program application ("Application") and verify the information contained in this Application; and (3) administer, analyze, and improve the FastAccess program, which includes comprehensive patient support services, such as benefits investigation and related coverage and reimbursement services to allow us to help to ensure that the patient is able to appropriately access the drug that you have prescribed. I confirm that I have secured all necessary authorizations and consents so that I may share the patient's health information with Exeltis and its affiliates, agents, representatives, and service providers.

The FastAccess program offers only the brand name medications listed within the offer, and as such, I elect the patient to receive these branded product(s). No generic substitution will be made.

Physician Signature: _____ Date: _____

Please fax form to: (877)-620-2849

FastAccess Prescription Order & Patient Support Program (for EMERGENCY ONLY)

FastAccess | Exeltis Rethinking healthcare

Eagle Pharmacy Contact Information:
Phone: (877)-303-7181 · Fax: (877)-620-2849

FastAccess Program ("Program") Confidential Application Form

Eagle Pharmacy has been retained by Exeltis to review Program applications and determine if patients have available resources to purchase prescribed medication. For patients that require expedited delivery because of an emergency situation, Benznidazole Tablets shall be provided at no charge from Exeltis' Patient Assistance Program (PAP) in order to expedite the delivery process.

The physician must fill out Section 1 through 6 below, and sign where indicated.

1. Physician Information

Physician Name: _____ Site/Facility Name: _____

Street Address: _____ City: _____ State: ____ Zip: _____

Office Contact: _____ Telephone: _____ Best time to call: _____

Fax: _____ NPI # _____

2. Prescription

Upon approval for assistance through the Program, medication will be shipped via Eagle Pharmacy.

Product Name: Benznidazole Tablets
Strength (check one): ☐ 100 mg ☐ 12.5 mg

Directions: _____

Quantity: _____ Refill(s): _____ DAW: 1

☐ Check box if prescription to be sent via eRx: Eagle Pharmacy
Lakeland, FL 33810
NPI# 1487905840
NABP# 5711975

Prescription only valid for US patients. Prescription only valid for one fill.

3. Patient Clinical Information

Patient Diagnosis/ICD-10 Code: B57. _____ Weight: _____

Other Health Conditions: ☐ No known _____

Allergies: ☐ No known _____

Medications and Supplements: ☐ No known _____

4. Shipping Information:

Address: _____

City: _____ State: _____ Zip Code: _____

5. Patient Information:

Patient Name: _____ Date of Birth: _____ Gender: ☐ male ☐ female ☐ n/a

Guardian Name: _____ Primary Language: _____

Phone Number: _____ Best time to call: _____

Email Address: _____

6. Physician Declaration

I certify that the above therapy is medically necessary, and that the information provided is accurate, to the best of my knowledge.

I certify that I am the prescriber who has prescribed Benznidazole Tablets to the above-named patient and that I provided the patient with the full Prescribing Information for Benznidazole Tablets. I authorize Exeltis and its affiliates, agents, representatives, and service providers to: (1) forward this prescription to a dispensing pharmacy that will dispense the medication to the above-named patient; (2) process this FastAccess program application ("Application") and verify the information contained in this Application; and (3) administer, analyze, and improve the FastAccess program, which includes comprehensive patient support services, such as benefits investigation and related coverage and reimbursement services to allow us to help to ensure that the patient is able to appropriately access the drug that you have prescribed. I confirm that I have secured all necessary authorizations and consents so that I may share the patient's health information with Exeltis and its affiliates, agents, representatives, and service providers.

The FastAccess program offers only the brand name medications listed within the offer, and as such, I elect the patient to receive these branded product(s). No generic substitution will be made.

Physician Signature: _____ Date: _____

Please fax form to: (877)-620-2849

FastAccess Prescription Order & Patient Support Program (for Physician Private Practice)

FastAccess | Exeltis Rethinking healthcare

Eagle Pharmacy Contact Information:
Phone: (877)-303-7181 · Fax: (877)-620-2849

FastAccess Program ("Program") Confidential Application Form

Eagle Pharmacy has been retained by Exeltis to review Program applications and determine a patient's benefits and if they have available resources to purchase prescribed medication. Reimbursement support will be provided for Benznidazole Tablets including benefit investigations, prior authorization, and appeals assistance. Eagle Pharmacy will determine if the patient is eligible for co-pay assistance or product at no charge, if they have no insurance or are underinsured.

The physician must fill out Section 1 through 6 below. The patient must fill out Section A through C below. Both the physician and patient must sign where indicated.

1. Physician Information

Physician Name: _____ Site/Facility Name: _____

Street Address: _____ City: _____ State: ____ Zip: _____

Office Contact: _____ Telephone: _____ Best time to call: _____

Fax: _____ NPI # _____

2. Prescription

Product Name: Benznidazole Tablets
Strength (check one): ☐ 100 mg ☐ 12.5 mg

Directions: _____

Quantity: _____ Refill(s): _____ DAW: 1

☐ Check box if prescription to be sent via eRx:

Eagle Pharmacy
Lakeland, FL 33810
NPI# 1487905840
NABP# 5711975

Prescription only valid for US patients.

3. Patient Clinical Information

Patient Diagnosis/ICD-10 Code: B57. _____ Weight: _____

Other Health Conditions: ☐ No known _____

Allergies: ☐ No known _____

Medications and Supplements: ☐ No known _____

4. Shipping Information:

Address: _____

City: _____ State: _____ Zip Code: _____

5. Patient Information:

Patient Name: _____ Date of Birth: _____ Gender: ☐ male ☐ female ☐ n/a

Guardian Name: _____ Primary Language: _____

Phone Number: _____ Best time to call: _____

Email Address: _____

A. Patient Pharmacy Insurance Information:

Primary Rx Insurer (BIN/PCN): _____ Telephone: _____

Member ID Number: _____ Rx Group Number: _____

Subscriber Name: _____ Date of Birth: _____

Secondary Rx Insurer (BIN/PCN): _____ Telephone: _____

Member ID Number: _____ Rx Group Number: _____

Subscriber Name: _____ Date of Birth: _____

Check here if patient has no insurance: ☐

Please include a photocopy of the patient's insurance card(s), if possible.

B. Patient Financial Information:

If you desire to be considered for co-pay or product support, please select the option that best represents your financial situation.

Number of People in your Household	Total Household Annual Income Before Taxes	Please Mark with an X
1	Less than $ 51,040	☐
2	Less than $ 68,960	☐
3	Less than $ 86,880	☐
4	Less than $104,800	☐
5	Less than $122,720	☐

I CERTIFY and attest that a true and accurate representation of my household income meets the program guidelines and that I am unable to afford the medication requested. I understand that the program can request additional information from me at any time.

C. Patient Authorization of the Program

I understand my healthcare provider has authorized the Program to perform the specified reimbursement support services on my behalf. I authorize my healthcare providers (e.g., physician, pharmacist) and my insurance company to disclose personal health information about me to Eagle Pharmacy, Exeltis, the Program, and their agents. Eagle Pharmacy, Exeltis, the Program, and their agents may contact me and use and release information about me only for the purposes of (i) assisting in my enrollment in the Program; (ii) performing the reimbursement support services specified herein; (iii) assessing my eligibility for co-pay assistance or free drug; and (iv) coordinating delivery of Benznidazole Tablets to my healthcare provider. I understand that some of my information may be provided anonymously and used in an individual or aggregated form for other legitimate purposes by Exeltis. I understand that reasonable efforts will be made to keep my information private even though some of my information which is re-disclosed under this authorization may no longer be protected under federal and state privacy laws.

Any co-pay assistance or drug furnished at no charge provided to me through the Program is contingent upon meeting certain eligibility criteria, and Exeltis may, at any time, and without notice, modify or discontinue the Program or any assistance provided directly to me.

I understand that I do not have to sign this authorization to obtain treatment or seek payment for treatment on my own; however, in order to be eligible for the services provided by the Program, I must sign the authorization. I understand that I may cancel my authorization, or opt out of receiving any of the above services or communications, at any time by contacting the Program at 877-303-7181 or by mail at P.O. Box 90937 / Lakeland, FL 33804. If I cancel the full authorization, then my healthcare providers and my insurance company will not provide any further information about me, and the Program will no longer be able to provide me with the assistance, education, or services described above.

The FastAccess program offers only the brand name medications listed within the offer, and as such, I elect to receive these branded product(s). No generic substitution will be made.

I verify that the information provided in this enrollment form is current, complete, and accurate.

This authorization expires in four (4) years.

By signing, I agree that I have read and agree to the authorization above:

Patient Signature: _____ Date: _____

Legal Guardian or Representative Signature: _____ Date: _____

Relationship to Patient: _____

6. Physician Declaration

I certify that the above therapy is medically necessary, and that the information provided is accurate, to the best of my knowledge.

I certify that I am the prescriber who has prescribed Benznidazole Tablets to the above-named patient and that I provided the patient with the full Prescribing Information for Benznidazole Tablets. I authorize Exeltis and its affiliates, agents, representatives, and service providers to: (1) forward this prescription to a dispensing pharmacy that will dispense the medication to the above-named patient; (2) process this FastAccess program application ("Application") and verify the information contained in this Application; and (3) administer, analyze, and improve the FastAccess program, which includes comprehensive patient support services, such as benefits investigation and related coverage and reimbursement services to allow us to help to ensure that the patient is able to appropriately access the drug that you have prescribed. I confirm that I have secured all necessary authorizations and consents so that I may share the patient's health information with Exeltis and its affiliates, agents, representatives, and service providers.

If checked below, as applicable, I authorize the Program to perform: (a) benefits investigation; (b) prior authorization; and (c) if needed, appeals support. I further authorize and request that the Program provide to me any and all information necessary for completing a Letter of Medical Necessity as may be required for all checked items.

Physician Signature: _____ Date: _____

Please fax form to: (877)-620-2849