fensolvi® (leuprolide acetate) for injectable suspension | fensolvi totalsolutions®

Please FAX Form to: 1-877-991-1798

For assistance – call ScriptsRx at 1-833-213-9520
Mon–Fri: 9AM–8PM ET | Sat: 11AM–3PM ET
To submit via eRx – search for Scripts Rx by NABP: 5922592 and NPI: 1144730995

Fensolvi Patient Enrollment Form

☐ Spec. Pharmacy Fulfillment ☐ Benefit Verification Only
☐ Patient Assistance Program (Additional form will be sent)

1. Patient Information

PATIENT LAST NAME	PATIENT FIRST NAME	SEX ☐ Male ☐ Female	DOB (MM/DD/YYYY)
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ADDRESS	CITY	STATE	ZIP

PARENT / CAREGIVER NAME (LAST, FIRST)	PARENT / CAREGIVER EMAIL	PARENT / CAREGIVER PHONE #

2. Insurance Information

Please include BOTH the Medical & Prescription Insurance Information

☐ Insurance Cards attached – or – ☐ Insurance Info Below

Medical Insurance Information

INSURANCE PROVIDER	INSURANCE PROVIDER PHONE #

SUBSCRIBER LAST NAME	SUBSCRIBER FIRST NAME

MEMBER ID #	GROUP #

Prescription Insurance Information

Rx BENEFIT PROVIDER	

Rx MEMBER ID #	Rx BIN #

Rx PCN #	Rx GROUP #

3. Prescriber Information

PRESCRIBER LAST NAME	PRESCRIBER FIRST NAME	NPI #	TAX ID #

ADDRESS	CITY	STATE	ZIP

PHONE #	FAX #

REIMBURSEMENT / CLINICAL CONTACT NAME	REIMBURSEMENT / CLINICAL CONTACT PHONE #

4. Specialty Pharmacy Fulfillment Preference

(In-Network Payer Network pharmacies will be prioritized)

☐ No Preference ☐ Accredo ☐ Kroger ☐ CVS/Caremark

5. Shipping Information

☐ Ship to Prescriber Address Above – or – ☐ Ship to Address Below

ADDRESS	CITY	STATE	ZIP

SHIPPING CONTACT NAME	PHONE #

6. Prescription Information

☐ ICD-10/Diagnosis Code: E30.1 ☐ ICD-10/Diagnosis Code: E22.8
☐ Other:

DIRECTIONS & ROUTE
Inject 45 mg subcutaneously every 6 months by a healthcare professional

QUANTITY	REFILLS 0 ☐ 1 ☐	CPT CODE	KNOWN ALLERGIES / OTHER CONDITIONS

By signing below, I verify that I am a practicing healthcare provider, authorized to request, prescribe and receive prescription medications at the address identified herein. I certify that the therapy prescribed is medically necessary and verify that the information provided is complete and accurate to the best of my knowledge. I further certify that (a) any reimbursement investigation service provided through Tolmar, Inc. ("Tolmar") and its agents is not made in exchange for any express or implied agreement or understanding that I would recommend, prescribe, or use the above therapy or any other product or service for or from anyone, and (b) my decision to prescribe the above therapy was based solely on my determination of medical necessity as set forth herein. I also attest that I have obtained all appropriate patient authorizations and consents, including a signed HIPAA authorization, to disclose the patient's protected health information, and such other information as may be required, to Tolmar and its agents, to use and disclose as may be necessary to assist in obtaining coverage for the product, initiating therapy, providing treatment support services, and administering the Fensolvi® programs. I affirm that the patient has been informed and agrees that (1) I, applicable pharmacies, and other health care providers, as well as the patient's health insurers, may share the patient's health information with Tolmar and its agents, including, but not limited to, reimbursement hub vendors, pharmacies, and data aggregators, pursuant to the HIPAA patient authorization, (2) Tolmar and its agents may provide the patient with various support and information to help the patient access Fensolvi and may contact the patient by email, telephone, voicemail, or text to do so, (3) Tolmar and its agents may use the patient's information for internal business purposes (such as marketing research, financial reporting, operations, and fulfillment of legal responsibilities), and (4) authorization is voluntary, may be revoked at any time by the patient once given, and refusal to consent will not affect the patient's ability to obtain treatment or insurance benefits.

I authorize Tolmar and its agents, and the dispensing pharmacy, to share information about the patient on my behalf, to convey this prescription to the pharmacy for dispensing, and for the pharmacy to dispense per its customary and usual procedures. I agree that I shall not bill, sell, seek reimbursement from the government or any third party or file any claim for the drug product provided by Tolmar TotalSolutions® or other Hub offering.

PRESCRIBER SIGNATURE:	DATE:

For Ohio Licensed Healthcare Practitioners Only Please visit the Ohio State Board of Pharmacy website (www.pharmacy.ohio.gov) for additional information on when a prescriber must hold a TDDD license.	**Please print/type your Terminal Distributor of Dangerous Drugs (TDDD) license number** (if applicable):	**Are you exempt from TDDD licensure?** ☐ Yes ☐ No

By checking "Yes," you attest that you meet one of the licensing exemptions under ORC 4729.541. Exemptions include but are not limited to: (1) prescribers who are sole proprietors; (2) business practices with a sole shareholder (per Ohio law, group practices with multiple shareholders are not exempt); and (3) dentists licensed by the Ohio Dental Board. Please visit the Ohio State Board of Pharmacy website for additional information. By checking "No," you attest that you have provided a valid TDDD license number above. Your signature serves as attestation and that you have the appropriate TDDD licensure or quality under and exemption.

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