



VIVAGLOBIN® RESOURCE CENTER

INSURANCE VERIFICATION REQUEST-PRESCRIPTION REFERRAL FORM

FAX 1-866-720-4373 TOLL-FREE 1-877-848-2456 (1-877-Vivaglobin)

Please complete the form. Submit via fax. Upon completion, a benefit information form will be faxed to you. Information may be shared with specialty pharmacies or other providers that may be able to assist you.

PATIENT INFORMATION

Name _____ DOB _____ SSN _____
 Address _____ Alternate Contact _____
 City _____ State _____ ZIP _____ Sex M F Weight _____ VIRTUE Patient
 Home Tel _____ Business Tel _____ Diagnosis (ICD-9) _____ Years with disease _____
 Current Therapy _____

PATIENT INSURANCE INFORMATION (Fax copy of insurance card[s] or provide the information below)

Insurance Company Name 1 _____ Insurance Company Name 2 _____
 MD Participating Status (check one) In Network Out of Network MD Participating Status (check one) In Network Out of Network
 Policyholder's Name _____ Policyholder's Name _____
 Employer _____ Employer _____
 Insurance Phone _____ Fax _____ Insurance Phone _____ Fax _____
 Group # _____ Policy # _____ Group # _____ Policy # _____

Select Preferred Specialty Pharmacy (SP): Patient's Insurer In Network Provider OR:

Accredo Apria BioScrip Caremark Coram CuraScript Medmark/Walgreens Nufactor OptionCare
 Other NBN INFUSIONS Contact Magued Saad Phone 856-669-6420 ext.200305
 Is patient currently being serviced by SP? Yes

TREATMENT SETTINGS & PATIENT TRAINING

Step 1 Initial Treatment Setting: Physician Office Outpatient Clinic Inpatient Home
1A Product will be supplied by: Physician Access Specialty Pharmacy Other _____
Step 2 Patient Training: Do you want the Specialty Pharmacy to train the patient? Yes No
Step 3 Final Treatment Setting: Physician Office Outpatient Clinic Inpatient Home
3A Product will be supplied by: Physician Access Specialty Pharmacy Other _____

CONVERSION:

Total monthly grams of Vivaglobin® _____ ÷ 0.160 grams per mL = _____ mL per month
 Divide mL per month into appropriate weekly dose and round to appropriate vial size(s).

Vivaglobin® (160 mg per mL)
 Available in 3 mL (0.48 g), 10 mL (1.6 g),
 or 20 mL (3.2 g) single-use vials

PRESCRIPTION FORM

Once the Vivaglobin® Resource Center completes the insurance verification, they will send this prescription to one of the specialty pharmacy partners for service.

RX: Total weekly dose _____ in grams (_____ Total mL) Vivaglobin® (160 mg per mL) to be infused simultaneously into
 1 – 2 – 3 – 4 _____ subcutaneous sites using a pump over _____ hours. Infusion frequency 1 – 2 – 3 _____ times per week.
 Rotate sites to maintain skin health. Dispense 4-week supply = _____ mL with _____ refills.

Dispense in combination of single-use vial sizes to equal total mL prescribed for each dose.

Prescription Type: New Continuing Therapy Restart Drug Allergies _____ NKA

Physician's Full Name _____

Facility or Physician Tax ID # _____ DEA # _____

State License # _____ NPI _____

Address _____ City/State/ZIP _____

Office Contact _____ Phone _____ Fax _____

Special Instructions _____

Pharmacy to provide anaphylactic kit per provider protocol Must select: Dispense as Written Substitution Permitted

PHYSICIAN'S SIGNATURE (required to process prescription) _____ Date _____

Physician Authorization (Required)

I certify that Vivaglobin® is medically necessary for this patient. I will be supervising the patient's treatment accordingly. Non-approval of Vivaglobin® may result in further deterioration of patient's health and/or hospitalization. By signing below, I certify that I have received the necessary written authorization to release the medical and/or other patient information referenced on this form relating to the above-referenced patient to CSL Behring's contracted agent or contractors for the purpose of seeking reimbursement through the Vivaglobin® Resource Center, verifying insurance coverage and/or the evaluation of the patient's eligibility for alternate sources of funding, and product fulfillment via specialty pharmacies.

PHYSICIAN'S SIGNATURE _____ Date _____

If you have questions, please call the Vivaglobin® Resource Center toll-free at 1-877-848-2456.
Our hours of operation are Monday through Friday from 8 am to 8 pm, Eastern Time.