EGRIFTA® Enrollment Form

EGRIFTA® tesamorelin for injection

To enroll, FAX all documents to 1-855-836-3069.

Please ensure all sections of the Form are completed in full, with supporting documents included.

Questions? Contact a Patient Care Coordinator at 1-833-23-THERA (1-833-238-4372), Mon-Fri 8 AM - 8 PM EST

Reset Form

1. Patient Information (THIS SECTION MUST BE FILLED OUT COMPLETELY.)

First Name _____ Date of Birth _____ MM/DD/YY _____ Gender ☐ M ☐ F

Last Name _____ Preferred Language ☐ English ☐ Other _____

Address _____ Telephone _____

City _____ State _____ Email _____

ZIP _____ SSN (last 4 digits) _____ Best time to contact ☐ AM ☐ PM ☐ Other _____

Alternate Contact/Caregiver _____ Telephone _____

Relationship to the Patient _____ ☐ OK to leave message

2. Medical History

The patient is currently receiving anti-retroviral therapy (ART) ☐ Yes ☐ No

Please provide the patient's:

Fasting Blood Glucose _____ mg/dL BMI _____ kg/m^2 _____

Waist Circumference _____ cm Hip Circumference _____ cm

Waist-to-hip Ratio _____

Waist-to-hip Ratio = Waist Circumference ÷ Hip Circumference

Concomitant Medications: _____

3. Insurance Information (THIS SECTION MUST BE FILLED OUT COMPLETELY.)

☐ **Patient does not have insurance**

☐ **Patient has insurance**

→ Please complete the information below and include copies of front and back of insurance card(s)

NOTE: Prescriptions cannot be processed unless copies of both sides of the insurance card(s) are included.

Prescription Drug Insurer/Pharmacy Benefit Manager (PBM)

_____

Telephone _____

Policy # _____

Rx BIN # _____

Rx Group # _____

Rx PCN # _____

4. Prescriber Information

First Name _____ NPI # _____

Last Name _____ Tax ID # _____

Specialty _____ Medicaid # _____

Office/Clinic/Institution _____ Office Contact _____

Address _____ Office Telephone _____

City _____ Office FAX _____

State _____ ZIP _____

Office Email _____

5. Prescription

☐ Rx: *EGRIFTA*® (tesamorelin for injection) 1 mg NDC: 62064-0011-60 [60 vials]

Diagnosis (ICD-10): ☐ E88.1 HIV-Associated Lipodystrophy

NOTE: Without providing the above diagnosis and diagnosis code, this form cannot be processed.

☑ Dispense Injection Kit

Dosage and Directions for Use: 2-mg subcutaneous injection daily (requires 2 vials of *EGRIFTA*®, 1 mg)

Dispense: ☐ 30-day supply with ☐ 11 Refills or ☐ Other _____

Dispense: ☐ 90-day supply with ☐ 3 Refills or ☐ Other _____

Additional Instructions _____

Preferred Specialty Pharmacy (optional) _____

6. Prescriber Authorization and Signature

I certify that the patient and physician information contained in this enrollment form is complete and accurate to the best of my knowledge. I have prescribed *EGRIFTA*® based on my judgment of medical necessity and I will be supervising the patient's treatment. I have received the necessary authorization prior to the transmittal of health information to Theratechnologies Inc., and parties working with Theratechnologies Inc., to perform preliminary assessment of insurance verification and determine patient eligibility for the THERA patient support™ program. I authorize the forwarding of this prescription to a dispensing specialty pharmacy on behalf of myself and the patient. I understand that neither I nor the patient should seek reimbursement for any free product received under the program.

State Prescription Requirements: The physician is to comply with their state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance of state-specific requirements could result in outreach to the prescriber.

Select one option:

☐ Prescriber's Signature _____

(no stamps; **Dispense As Written**) Date _____ MM/DD/YY

OR

☐ Prescriber's Signature _____

(no stamps; **Substitution Permissible**) Date _____ MM/DD/YY

NOTE: Physician needs to sign and date in order for the prescription to be filled.

THERA patient support™