TotalCareRX
SPECIALTY PHARMACY

Before submitting this form, please ensure:

- ☐ This enrollment form is complete with all required information requested and the prescriber's signature
- ☐ Copies of the health insurance and prescription drug coverage cards are provided
- ☐ A separate prescription for EPIDIOLEX is sent via mail or e-prescribed
- ☐ Please include last office note, EEG, and liver labs if you would like the PA assistance

SECTION 1: PRESCRIBER INFORMATION

Prescriber Name: _____ Specialty: _____

Physician Practice Name: _____ Office Contact Name: _____

Office Contact Phone: _____ Fax: _____

Office Email: _____

Office Street Address: _____

City: _____ State: _____ ZIP Code: _____

NPI # _____ DEA # _____ State License # _____

SECTION 2: PATIENT INFORMATION

Patient First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ Gender: ☐ Male ☐ Female Weight _____ kg

Patient Street Address: _____

City: _____ State: _____ ZIP Code: _____

Is the patient under the age of 18 or under legal guardianship? ☐ Y ☐ N

Legal Guardian First and Last Name: _____ Email Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Preferred method of contact (optional) ☐ Home ☐ Work ☐ Cell

Best time to contact (optional) ☐ Morning ☐ Afternoon ☐ Evening

Diagnosis:

The diagnosis designations below are intended to ensure communication of accurate information to your patient's insurance plan. **EPIDIOLEX is approved to treat seizures associated only with Lennox-Gastaut syndrome or Dravet syndrome in patients 2 years of age and older.**

☐ Seizures associated with Lennox-Gastaut syndrome ☐ Seizures associated with Dravet syndrome

☐ Other (please specify) _____

If prescribing this medication for a use that is not listed on the FDA-approved label, by signing below and initialing here, I certify that this prescription is medically necessary and appropriate for this patient and, as the treating physician, I will be supervising this patient's treatment with the prescribed medication.

Prescriber's initials _____ **Date** _____

Is the patient experiencing seizures? ☐ Y ☐ N

What antiseizure medications is the patient currently taking? _____

What antiseizure medications has the patient tried and failed? (optional) _____

Note: This information may be needed if a prior authorization is required.

SECTION 3: INSURANCE INFORMATION

Does the patient have prescription drug coverage? ☐ Yes ☐ No

If you answered ***yes*** to having prescription drug coverage, which may be different than the health insurance, **please provide the following information and a copy of the front and back of the prescription drug card.** If you answered ***no***, you may skip this section.

Prescription Drug Insurance Provider Name:

Insurer Name: _____ Insurer Phone: _____

Rx ID Number: _____ Rx PCN: _____

Rx BIN Number: _____ Rx Group Number: _____

Patient's relationship to cardholder: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Does the patient have other health insurance? ☐ Y ☐ N

If you answered ***yes*** to having other health insurance, please provide the following information and a copy of the front and back of the insurance card. If you answered ***no***, you may skip this section.

Other Insurance Provider Name: _____

Policy ID Number: _____ Group Number: _____

Insurer Phone: _____ Cardholder Name: _____

Patient's relationship to cardholder: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

SECTION 4: PRESCRIBER AUTHORIZATION

I authorize the use or disclosure of the patient's health information contained on this enrollment form to the patient's other healthcare providers (including pharmacies and Greenwich Biosciences, Inc.), health insurers, and their respective agents and contractors, and other designees, that are involved in the patient's treatment, to: (1) determine the patient's insurance benefits for EPIDIOLEX; (2) transmit the prescription and other necessary information, to a pharmacy that will fill the patient's prescription, and to obtain information from the pharmacy regarding delivery of such prescribed medication and related matters; (3) contact the patient to obtain any other necessary signatures, consents or information relating to the patient's treatment; (4) contact the patient in order to ask whether the patient would like to apply for the Greenwich Biosciences Patient Assistance Program, and to request information from the patient or from patient's designees needed to determine eligibility for the program; and (5) to provide other related care coordination services. I certify that I have obtained my patient's authorization as required by HIPAA to use and disclose patient's personally identifiable health information (including diagnosis, treatment, and insurance information, contained in this form), for the purposes permitted under this "Prescriber Authorization" Section. I agree that the patient's providers, insurers, pharmacies and other designees may contact me for additional information as needed relating to the patient's EPIDIOLEX therapy.

I certify that: I am the physician who has prescribed EPIDIOLEX to the identified patient; EPIDIOLEX is medically necessary for this patient; and the information provided on this form is accurate to the best of my knowledge.

Prescriber's Signature _____ **Date** _____

SECTION 5: OPTIONAL HIPAA PATIENT AUTHORIZATION FORM

FAX ORDERS TO	E-PRESCRIBE
TOTAL CARE RX 718.504.7426	TOTAL CARE RX NCPDP: 3364510

ADDRESS: 223-10 Union Turnpike Oakland Gardens, NY 11364

For any questions please contact Neurology: 718.762.7111 ext 663
EMAIL: NEURO@TOTALCARERX.COM

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