GATTEX® Referral Form

Step 1: Complete the following information to register the patient and your office for NPS Advantage™. This form will also act as a prescription for GATTEX. Please include copies of all insurance cards. Please print legibly, using blue or black ink.

Patient Information

First Name: ______________________ MI: ____ Last Name: ______________________

Address 1: ______________________ Address 2: ______________________

City: ____________ State: ____ Zip: ________ DOB: ____________ Gender: ☐ Male ☐ Female

Preferred Phone #: ______________________ Can we leave a message on this phone? ☐ Yes ☐ No

Authorized Contact: ______________________ Phone #: ______________________

Home Infusion Provider Information

Home Infusion Provider: ______________________ Phone #: ______________________

Insurance Information (Provide a copy of insurance and prescription cards, front and back, if available)

Primary Insurance: ______________________ Secondary Insurance: ______________________

Policy Holder: ______________________ Policy Holder: ______________________

Policy ID #: ______________________ Policy ID #: ______________________

Group #: ______________________ Group #: ______________________

Phone #: ______________________ Phone #: ______________________

Prescription Card (name): ______________________ Phone #: ______________________

Group #: ____________ ID #: ____________ Rx Bin #: ____________

Prescriber Information

First Name: ______________________ Last Name: ______________________

Office/Institution: ______________________

Address: ______________________

City: ____________ State: ____ Zip: ________ Phone #: ____________ Fax #: ____________

E-mail: ______________________ NPI #: ____________ DEA #: ____________

Contact Person: ______________________ Contact Phone # (direct): ______________________

Prescription Information

℞

Teduglutide [rDNA origin] for Injection NDC #: 68875-0102-1 ICD-9 Code: ______________________

Dose: 0.05 mg/kg/day Patient Weight (kg): ______________________

Dosing Instructions (weight [kg] divided by 200 = mL/day): ________ mL/day x 30 days No. of Refills: ________

Home Health

☐ My patient requires a home nurse visit for training on proper self-administration of GATTEX.

Choose your preferred Specialty Infusion Pharmacy for GATTEX delivery

☐ Accredo ☐ BioScrip ☐ BioRx/ThriveRx ☐ Coram ☐ Walgreens Infusion Services ☐ No preference

I certify that the above therapy is medically necessary and the information provided is accurate to the best of my knowledge. I appoint NPS Advantage™, on my behalf, to convey this prescription to the dispensing pharmacy.

Prescriber's Signature: ______________________ Date: ____________

(No stamped signatures permitted)

Agent of Prescriber: ______________________

Remember to complete the Patient Authorization

Gattex®
(Teduglutide [rDNA origin]) for Injection

GATTEX® Referral Form

Step 2: Obtain patient authorization. Please have patient review and sign authorization below.

Patient Authorization for Use and Disclosure of Health Information Pursuant to 45 C.F.R. §164.508

By signing this authorization ("Authorization"), I hereby certify and agree to the following:

I am (i) the Patient (identified in Step 1 above) and legally permitted to make decisions about how my health information is used and disclosed or (ii) the parent, legal guardian, or authorized representative of the Patient and legally permitted to make decisions about how the Patient's health information is used and disclosed.

I authorize the Patient's Healthcare Providers and Payors (as defined below) to use and disclose all the Patient's protected medical and prescription information relating to the Patient's use of and/or need for GATTEX® (Teduglutide [rDNA origin]) for Injection as well as information related to the monitoring and management of GATTEX for the Patient, including, but not limited to the information contained in the "NPS Advantage Prescription and Service Request Form," the Patient's prescription and insurance information for GATTEX, and information about the Patient's PN and fluid requirements, which may include information relating to HIV/communicable disease, mental health and/or drug & alcohol treatment (collectively, "GATTEX Information") to NPS Pharmaceuticals, Inc. ("NPS"), United BioSource Corporation, the GATTEX Program Administrators, and their respective contractors (collectively, "Recipients") for the Purposes (as defined below) set forth in this Authorization. I authorize the Patient's Healthcare Providers and Payors, and the Recipients of the GATTEX Information, to contact the Patient at the Patient's contact information in his or her records or as set forth above through text, telephone (including mobile phone), fax, and/or mail for the Purposes (as defined below) set forth in this Authorization.

For purposes of this Authorization, the "Patient's Healthcare Providers and Payors" shall mean all (i) healthcare providers, such as the Patient's prescriber, pharmacy and support services provider, who are involved in the prescribing, dispensing, and/or management of GATTEX for the Patient and/or the provision of support services to the Patient related to the Patient's GATTEX prescription and (ii) the insurers and/or payors for the Patient's GATTEX prescription and related healthcare services. The "Purposes" for which the Patient's Healthcare Providers and Payors may use or disclose the Patient's GATTEX Information under this Authorization are as follows: (i) to provide GATTEX and related services to the Patient and to coordinate care for the Patient related to the Patient's GATTEX prescription, (ii) to determine the Patient's insurance eligibility, coverage and payment obligations for GATTEX, (iii) so the Patient may receive educational and therapy support services, such as injection training, patient education, and other support services (including educational brochures and treatment reminder calls, emails, letters or text messages) through NPS Advantage and/or its contracted healthcare providers, (iv) to address complaints and adverse events related to GATTEX and (v) to analyze the data for the Recipient's business or scientific purposes.

This Authorization expires three (3) years after NPS receives written notice from the Patient that he or she chooses to no longer participate in NPS Advantage, or sooner if required by applicable laws. I acknowledge that this Authorization may authorize uses and disclosures of the Patient's GATTEX Information even after the Patient has stopped using GATTEX. I understand that NPS will compensate certain of the Patient's health care providers for services, including the collection and provision of data to NPS and/or its agents, which may include the Patient's GATTEX Information, and I consent to such GATTEX Information being subsequently disclosed by the recipients for payment so long as the reason for such subsequent disclosure is for one or more of the Purposes outlined in this Authorization.

I may refuse to sign this Authorization; however, my refusal to sign the Authorization will not prevent the Patient's Healthcare Providers and Payors from using and disclosing the Patient's GATTEX Information for purposes for which the Patient's authorization is not required by law. Further, refusal to sign this Authorization will not adversely affect the Patient's ability to receive treatment, payment, enrollment or eligibility for benefits.

I understand that I can revoke this Authorization by notifying NPS Advantage in writing at the following address: 550 Hills Drive, 3rd floor, Bedminster, New Jersey 07921. I understand that NPS will in turn notify the Patient's Healthcare Providers and Payors and Recipients of such revocation. My revocation will be effective upon receipt, but will not be effective to the extent that Patient's Healthcare Provider and Payors, Recipients, or others have acted in reliance upon this Authorization prior to receiving notice of such revocation from NPS.

I understand that information disclosed pursuant to this Authorization could be re-disclosed by Recipients. Such re-disclosed information may no longer be protected by federal or state medical privacy laws, including the federal Health Insurance Portability and Accountability Act or "HIPAA."

I have received a copy of this Authorization.

______________________________ ____________
Patient's Signature Date

______________________________ ____________
Patient's Name (please print) Date

______________________________ ____________
Patient's Address Date of Birth

______________________________ ____________
Patient's Guardian (please print) Relationship to Patient

______________________________ ____________
Guardian's Signature Date

Step 3: Submit the completed form.

Mail forms to:
NPS Advantage
550 Hills Drive
Bedminster, NJ 07921

Fax forms to:
1-908-450-5576

Questions or Concerns?

Call NPS toll-free:
1-855-TEAM-NPS (832-6677)
9:00AM to 6:00PM EST

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