Orsini
Specialty Pharmacy Services

Vyndaqel Enrollment Form

Complete and fax this completed form, along with copies of both sides of the patient's insurance cards, to 1-877-684-3116. If you have questions, please call 1-800-930-2043, Monday-Friday, 8 AM-8 PM CST.

For Patients Fields marked with * are required.

1. Patient Information			
Name (First, MI, Last)*			Gender* ☐ Male ☐ Female
Date of Birth (mm/dd/yyyy)*	Email		
Street Address*			
City*		State*	ZIP Code*
Primary Phone* ☐ OK to leave message		Language Preference	
☐ Patient Caregiver	Caregiver Name	Caregiver Phone	

2. Insurance Information (Please include a copy of both sides of your insurance and prescription card[s])		
☐ Check here if patient does **not** have insurance ☐ Check here if patient has secondary insurance		
Primary Insurance Name*		
Primary Insurance Phone Number*	Policy/Group #*	
Primary Policyholder Name (First, MI, Last) (if other than patient)*		
Primary Policyholder Date of Birth (mm/dd/yyyy)*	Primary Policyholder Relationship to Patient	
Prescription (Rx) Insurance Name*(if applicable)		
Policy #*	Group #*	Rx Bin #*
If the patient is insured through a Medicare Prescription Drug Plan, please include the full plan address‡:		

For Healthcare Providers Fields marked with * are required.

3. Healthcare Provider Information				
HCP Name (First, MI, Last)*	Practice/Institution Name*		Specialty*	
Street Address*				
City*			State*	ZIP Code*
Phone*	Fax*	NPI #*	State License #*	
Office Contact Name*	Office Contact Phone*	Email		

4. VYNDAQEL® (tafamidis meglumine) Prescription Information		
Patient Name (First, MI, Last)*	Patient Date of Birth (mm/dd/yyyy)*	☐ I confirm that my patient is being prescribed VYNDAQEL for the treatment of ATTR-CM
☐ I attest that my patient's diagnosis was confirmed.	Please list type of diagnostic test:	
Primary ICD-10 Diagnosis Code*	Secondary ICD-10 Diagnosis Code	
Dose* ☐ VYNDAQEL 80 mg (four 20-mg tafamidis meglumine capsules) orally once daily, Quantity #120 capsules (30 days)		Refills*
Drug Allergies: ☐ No ☐ Yes (If yes, please list medication(s) and associated reaction(s)):		
Patient's Concurrent Medications:		
Other Known Conditions:		

HEALTHCARE PROVIDER SIGNATURE

_____ _____ _____ _____

Product Substitution Permitted Signature | Date of Signature | Dispense as Written Signature | Date of Signature