



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* <input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth (mm/dd/yyyy)*		Email
Street Address*		
City*		State* <input type="checkbox"/>
Primary Phone* <input type="checkbox"/> OK to leave message		Language Preference
<input type="checkbox"/> Patient Caregiver	Caregiver Name <input type="checkbox"/> Caregiver Phone	

2. Insurance Information (Please include a copy of both sides of your insurance and prescription card[s])		
<input type="checkbox"/> Check here if patient does not have insurance <input type="checkbox"/> 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* <input type="checkbox"/>
Specialty*		
Street Address*		
City* <input type="checkbox"/>		State* <input type="checkbox"/> ZIP Code*
Phone* <input type="checkbox"/>	Fax* <input type="checkbox"/>	NPI #* <input type="checkbox"/> State License #*
Office Contact Name* <input type="checkbox"/>	Office Contact Phone* <input type="checkbox"/>	Email <input type="checkbox"/>

4. VYNDAQEL® (tafamidis meglumine) Prescription Information		
Patient Name (First, MI, Last)*		Patient Date of Birth (mm/dd/yyyy)* <input type="checkbox"/> I confirm that my patient is being prescribed VYNDAQEL for the treatment of ATTR-CM
<input type="checkbox"/> I attest that my patient's diagnosis was confirmed.		Please list type of diagnostic test:
Primary ICD-10 Diagnosis Code* <input type="checkbox"/>		Secondary ICD-10 Diagnosis Code <input type="checkbox"/>
Dose* <input type="checkbox"/> VYNDAQEL 80 mg (four 20-mg tafamidis meglumine capsules) orally once daily, Quantity #120 capsules (30 days) <input type="checkbox"/> Refills*		
Drug Allergies: <input type="checkbox"/> No <input type="checkbox"/> 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

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