



JazzCares for VYXEOS®
Enrollment and Patient Authorization Form

Call Toll Free: 1-855-589-9367
 Monday-Friday: 8:00 am to 8:00 pm, ET
 Fax to: 1-855-593-3955

Patient Authorization on the back of this form must be signed by the patient to participate in JazzCares Program

Patient Information	
*Patient name:	
* <input type="checkbox"/> Male <input type="checkbox"/> Female	*DOB: / /
*Address:	
*City/State/Zip:	
*Home Phone:	*Cell Phone:
Email:	
Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other	
Best Time to Contact: <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening	

Insurance Information	
<i>Please include copy of front and back of Patient's Insurance card(s)</i>	
*Primary Insurance:	*Policy ID #:
Group #:	Phone #:
Subscriber's Name: (if not self)	Employer:
Secondary Insurance:	Policy ID #:
Group #:	Phone #:
Subscriber's Name: (if not self)	Employer:

Physician Information	
*Physician Name:	MD Specialty:
Practice Name:	Office Contact:
*NPI #:	State Med Lic #:
Tax ID #:	PTAN:
*Address:	
*City/State/Zip:	
Phone:	Fax:
Email:	
Setting of Care: <input type="checkbox"/> Physician's Office <input type="checkbox"/> Outpatient Hospital <input type="checkbox"/> Other (explain):	
Is doctor contracted with patient's insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Diagnosis & Clinical Information	
*Diagnosis (Please indicate ICD-10 Code):	
ICD-10 Description:	
*Has this patient been diagnosed with newly diagnosed acute myeloid leukemia (t-AML) or acute myeloid leukemia with myelodysplasia-related changes (AML-MRC)?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Currently taking VYXEOS? <input type="checkbox"/> Yes <input type="checkbox"/> No	Start Date: / /

Treatment Information		
Product Requested	Dose	Treatment Date(s)
VYXEOS		
Other Drug(s) prescribed with VYXEOS:		
CPT Code(s):		

Physician's Signature
By signing below, I certify that (a) the above-prescribed therapy is medically necessary and, (b) I have received from the patient identified above, or his/her personal representative, the necessary authorization to release, in accordance with applicable federal and state privacy laws and regulations, referenced medical and/or other patient information relating to the need for the above-prescribed therapy(ies), to Jazz Pharmaceuticals and its affiliates or vendors for the purpose of seeking information related to coverage for the therapy(ies) and/or assisting in initiating or continuing therapy.
**Physician's Signature (NO STAMPS PLEASE):
Date:

****Please complete the Patient Authorization on the back of this form.**



JazzCares for VYXEOS®
Enrollment and Patient Authorization Form

Call Toll Free: 1-855-589-9367
Monday-Friday: 8:00 am to 8:00 pm, ET
Fax to: 1-855-593-3955

Please Print

Prescriber Name

Patient Name

Patient Authorization (“Authorization”)

(SIGNATURE IS REQUIRED FOR PARTICIPATION IN JAZZCARES FOR VYXEOS)

I hereby authorize my prescriber(s) and their staff and my health insurer(s) to disclose my personal health information (“Personal Health Information” or “PHI”) to Jazz Pharmaceuticals (including its affiliates and vendors who help provide the services) (together “Jazz Pharmaceuticals”) for the JazzCares VYXEOS Program (the “Program”).

I understand and authorize Jazz Pharmaceuticals to use the PHI it receives as a result of this Authorization for the following purposes: (i) enrolling me in the Program; (ii) verifying, investigating, coordinating and resolving insurance coverage or reimbursement inquiries and payment for VYXEOS; (iii) coordinating my receipt of and payment for VYXEOS; (iv) contacting me about the Program (this may include supplemental educational materials, information, offers and services related to my therapy or my medical condition, or opportunities to participate in focus groups, surveys or interviews); (v) contacting and providing my PHI to patient advocacy organizations, patient assistance programs, co-pay assistance or similar programs to determine eligibility for coverage and enrollment; (iv) de-identifying my PHI by aggregating it for research purposes, and (v) managing the Program.

I understand and authorize Jazz Pharmaceuticals to contact me through a variety of means including email, postal mail, phone, or fax, unless I opt out of these communications by contacting Jazz Pharmaceuticals using the contact information below.

I understand Jazz Pharmaceuticals will not disclose my Personal Information to a third-party that is not related to the Program (such as a family member or friend) unless I specifically authorize Jazz to do so. If I request that a person or an entity other than Jazz Pharmaceuticals receives my PHI, I understand the receiver may not be subject to HIPAA or other privacy laws and the PHI might be re-disclosed by the recipient and no longer protected by HIPAA or other privacy laws.

I understand I may refuse to sign this Authorization and my refusal will not affect the treatment I receive from my prescriber(s) and their staff, and my health insurer(s). I also understand that if I revoke this Authorization, I may no longer be eligible to participate in the Program. I understand I may revoke this Authorization at any time in the future except to the extent Jazz Pharmaceuticals has already taken action in reliance on this Authorization and my future revocation will not affect the treatment I receive from my prescriber(s) and their staff, and my health insurer(s); but if I revoke this authorization I may no longer be eligible to participate in the Program.

This Authorization will remain valid for five (5) years after the date of my signature unless a shorter time is required by state law. I can also revoke it earlier by calling 1-866-997-3688 or sending my request to JazzCares VYXEOS Program 400 Holiday Drive, Foster-0, Floor 3, Pittsburgh, PA 15220. I also understand the Program may be changed or ended at any time without prior notification. I understand I may request a copy of this Authorization that is on file with Jazz.

I verify the information provided is true and correct. If I am the caregiver for the patient, I confirm I am authorized to sign on behalf of the patient.

Patient/Guardian Signature:

Date: