CHIESI

CARE DIRECT®

Phone: 1-888-865-1222

Fax this form to: 1-866-410-6241

Pertzye® (pancrelipase) Delayed-Release Capsules | QuickStart Program Request Form

Receive a 21-day supply of Pertzye (pancrelipase) while the first prescription is being processed

PATIENT ELIGIBILITY

Patients may be eligible if they:

- are **new to Pertzye** (pancrelipase) and **have not filled a prescription** in the last 180 days
- have signed a **completed Service Request and Prescription** for Pertzye
- **have commercial insurance** (non-Medicare, non-Medicaid)

Eligible, commercially insured patients who are new to Pertzye (pancrelipase) and have not filled a prescription in the last 180 days will receive a 21-day supply of Pertzye as prescribed by a healthcare professional. Cash-paying patients are not eligible for this program. You are not eligible if prescriptions are paid in whole or in part by any state or federally funded programs, including, but not limited to, Medicare (including Medicare Part D) or Medicaid, Medigap, VA, DOD or TRICARE. Only valid in U.S. and Puerto Rico. Offer not valid where prohibited by law, taxed, or restricted. Other restrictions may apply. You must present this Pertzye QuickStart Program form together with a completed Service Request & Prescription form in order to participate in or in order to reduce the amount you pay on eligible prescriptions. The Pertzye QuickStart Program is not health insurance. Chiesi has the right to modify or terminate this offer at any time without notice. Your acceptance of this offer confirms that this offer is consistent with your insurance and that you will report the value received as may be required by your insurance provider. When you use this program, you are certifying that you understand and will comply with the program rules, regulations, and terms and conditions.

STEP 1: Complete Patient Information

Full Name (First, M.I., Last): _____ DOB: ____/____/____

Sex: ❑ Male ❑ Female Weight: _____ Height: _____ Email: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Ship to Address: *(If different)* _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____

I understand that my pharmacy providers may receive remuneration for disclosing my Personal Health Information pursuant to this Authorization. I further authorize my pharmacy providers to use my Personal Health Information to communicate with me about the drug that has been prescribed for me and understand that they may receive a fee for such communications.

Patient signature: _____ Date: _____

STEP 2: Complete Physician Information

Name: _____ Contact Name: _____

Practice Name/Institution/Department: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

State Medical Lic. #: _____ NPI #: _____

STEP 3: Complete Prescription and Statement of Medical Necessity

Rx

Check if applies: ❑ Contact me before sending Rx to Specialty Pharmacy

❑ **PERTZYE** (pancrelipase) Delayed-Release Capsules

Check one: ❑ PERTZYE 8,000 ❑ PERTZYE 16,000

SIG: Dose _____ Caps / day: _____ x 21 days Caps / meal: _____ Caps / snack: _____

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 Chiesi and its agents or contractors for the purpose of seeking information related to coverage for the therapy(ies) and/or assisting in initiating or continuing therapy.

Prescriber's signature: _____ Date: _____