

Synribo[®] Enrollment Form



toll-free phone 855.611.3399
toll-free fax 855.423.8300

Patient Information

patient: _____ male
last name, first name female DOB: _____ SS#: _____

address: _____
street city state zip

primary phone number: _____ cell alternate phone number: _____ cell

caregiver: _____ caregiver phone number: _____

allergies: _____ NKDA

Clinical Information

Primary Diagnosis/ICD-10: C91.12 C92.10 C92.11 C92.12 other (please specify): _____

Complete this section ONLY if you would like Thrifty White Pharmacy to initiate a prior authorization or appeal on your behalf:

reason for discontinuation of therapy

prior therapy	resistance	intolerance (please specify)	other (please specify)	year of discontinuation
Gleevec [®]				
Sprycel [®]				
Tasigna [®]				
Other (please specify) _____				

patient weight: _____ lbs kg date: _____ patient height: _____ inches cm BSA¹: _____ m²

¹BSA calculator available at synribohcp.com

Prescription Information	directions	quantity	refills
Synribo [®] 3.5 mg (1 mL) single-use vial (prescriber office administration)	induction dosing Inject _____ mg Sub-Q BID for 14 days of a 28—day cycle	_____ single-use vials	_____
	maintenance dosing Inject _____ mg Sub-Q BID for 7 days of a 28—day cycle	_____ single-use vials	_____
Synribo [®] _____ mg (1 mL) prefilled syringe ² (patient home administration)	induction dosing Inject _____ mg Sub-Q BID for 14 days of a 28—day cycle	_____ single-use vials ³	_____
	maintenance dosing Inject _____ mg Sub-Q BID for 7 days of a 28—day cycle	_____ single-use vials ³	_____

Thrifty White Pharmacy to coordinate shipment in accordance with drug stability (144 hours [6 days] after reconstitution)

³ 1 vial = 1 prefilled syringe, unless the dose is > 3.5 mg (1 mL)

Prescriber + Shipping Information

prescriber (print): _____ office contact: _____

preferred method of contact: phone fax email preferred contact persons email: _____

ship to: patient office alternate: _____
street city state zip

office address: _____
(street, suite, city, state, zip)

phone: _____ fax: _____ NPI: _____ DEA: _____

prescriber's signature: _____ date: _____

I authorize Thrifty White Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to Thrifty White Specialty Pharmacy.

Insurance Information: please fax copy of insurance card (front + back)

Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately by calling 855-611-3399 or by emailing specialty@thriftywhite.com to obtain instructions as to the proper destruction of the transmitted material. Thank you.



www.thriftywhite.com

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