VARUBI® (rolapitant) Prescription Referral Form

For VARUBI specialty pharmacy services for your patients, please fax completed referral forms to Biologics, Inc. at 1-800-823-4506

OR contact Biologics, Inc. at 1-800-850-4306 option 2 | Website: www.biologicsinc.com

Please complete all sections on both pages of this form to ensure your patient receives VARUBI as soon as possible.

Please include your patient's relevant treatment history and clinic notes to support the prior authorization process.

❍ **Contact Prescriber with results of benefits investigation before initiating dispense or contacting patient.**

1 Prescriber Information

Prescriber's Name: ______

NPI #: ______ DEA #: ______

PTAN #: ______ Tax ID #: ______

Site/Facility Name: ______

Mailing Address: ______

City: ______ State: ______ ZIP: ______

Office Contact's Name: ______

Office Contact's Phone #: ______ Fax #: ______

Office Contact's Email: ______

2 Patient Information

Patient's Name: ______

Sex: ❍ Male ❍ Female Date of Birth: ______

Patient's Address: ______

City: ______ State: ______ ZIP: ______

Home Phone #: ______ Cell Phone #: ______

Email: ______

Alt. Contact Name: ______

Alt. Contact Relationship: ______

Alt. Contact Phone #: ______

3 Prescription Information (Check all that apply)

❍ **Rx for VARUBI (rolapitant).**
VARUBI is supplied as a single dose wallet card containing two 90 mg tablets

Quantity: 2 tablets (1 wallet card) Refills: ______ **Target Start Date:** ______

Directions for Use: Take two tablets by mouth approximately 1-2 hours prior to chemotherapy, as directed by your physician.

Other Directions:

Prescriber's Name (Please print): ______

Prescriber's Signature (No Stamps Please):

______ Date: ______

Please attach a separate prescription if this section does not comply with your state's prescription law.

❍ **First Dose Program Rx for VARUBI (rolapitant).**
VARUBI is supplied as a single dose wallet card containing two 90 mg tablets

Quantity: 2 tablets (1 wallet card) Refills: None **Target Start Date:** ______

Directions for Use: Take two tablets by mouth approximately 1-2 hours prior to chemotherapy, as directed by your physician.

Other Directions:

❍ First Dose will always be shipped to the prescriber address provided in Section 1 unless this box is checked, indicating to ship to patient's home.

In the event there is a delay in securing prescription coverage, I authorize TESARO, Inc. and Biologics, Inc. to dispense VARUBI directly to the patient as part of the First Dose Program.

Prescriber's Name (Please print): ______

Prescriber's Signature (No Stamps Please):

______ Date: ______

For more information, please contact Biologics, Inc. at 1-800-850-4306 option 2 | Website: www.biologicsinc.com
You may also contact the TOGETHER with TESARO™ Patient Resource Program at 1-844-2TESARO (1-844-283-7276)

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4 Patient's Clinical Information

Cancer Diagnosis: ______________________________ Cancer ICD-9/10 Code: ______________________

Supportive Care Diagnosis: ______________________ Supportive Care ICD-9/10 Code: ______________________

Expected Chemotherapy Cycle Frequency: ____________ Expected Chemotherapy Duration: ______________________

Prior Supportive Care Therapies: ______________________ Drug Allergies: ______________________

Notes:

5 Insurance Information

Please check the relevant boxes below.

❍ Patient does not have insurance
To enroll your patient in the Patient Assistance Program (PAP), please complete the PAP application page of the TOGETHER with TESARO™ Enrollment Form and fax to TOGETHER with TESARO.

❍ I authorize this information to be transferred to TOGETHER with TESARO if PAP is needed for a patient considered to be uninsured or underinsured

❍ Insurance information provided below

❍ Copy of both sides of the patient's insurance card attached

Medical Insurance Plan:

❍ Medicare ❍ Medicaid ❍ Commercial/Private ❍ Other

Primary Insurance: ______________________

Phone #: ______________________

Policy ID #: ____________ Group #: ____________

Policy Holder's Name: ______________________

Policy Holder's Date of Birth: ______________________

Policy Holder's Relationship to Patient: ______________________

Prescription Drug Insurance Plan:

❍ Medicare ❍ Medicaid ❍ Commercial/Private ❍ Other

Prescription Insurance: ______________________

Phone #: ______________________

Policy ID #: ____________ Group #: ____________

Policy Holder's Name: ______________________

Policy Holder's Date of Birth: ______________________

Policy Holder's Relationship to Patient: ______________________

6 Preferred Shipping Location

Please indicate the preferred shipping address (Check one):

❍ Prescriber's Office (address from Section 1 on previous page)

❍ Patient's Address (address from Section 2 on previous page)

❍ Other Address:
Street: ______________________
City: ______________ State: ______ ZIP: ________

Patient's Name: ______________________________ Patient's Date of Birth: ____ /____ /______
(MM) (DD) (YYYY)

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