AVYXASSIST®

Visit us at www.avyxassist.com

PRODUCT CLAIM SUPPORT PROGRAM

ENROLLMENT FORM

Call us at **866-939-8927 Monday - Friday 8:00 AM - 8:00 PM (EST)**
Fax: 833-852-3420

Please complete this form and submit all required documentation to AVYXASSIST® via **fax at 833-852-3420.**

Date _____ Total Dates of Service _____

Product:

◯ AVGEMSI® (gemcitabine) injection	Strength_____	NDC_____	Vial Quantity_____
◯ AVOPEF™ (etoposide) injection*	Strength_____	NDC_____	Vial Quantity_____
◯ AXTLE® (pemetrexed) for injection	Strength_____	NDC_____	Vial Quantity_____
◯ DOCIVYX® (docetaxel) injection**	Strength_____	NDC_____	Vial Quantity_____
◯ FAVLYXA™ (fluorouracil) injection***	Strength_____	NDC_____	Vial Quantity_____
◯ FRINDOVYX® (cyclophosphamide) injection	Strength_____	NDC_____	Vial Quantity_____
◯ KYXATA® (carboplatin) injection****	Strength_____	NDC_____	Vial Quantity_____
◯ LUTRATE® DEPOT (leuprolide acetate) for depot suspension	Strength_____	NDC_____	Vial Quantity_____
◯ NAVITRUX™ (fosaprepitant) for injection	Strength_____	NDC_____	Vial Quantity_____
◯ POSFREA® (palonosetron) injection	Strength_____	NDC_____	Vial Quantity_____
◯ VYKOURA™ (leucovorin calcium) injection	Strength_____	NDC_____	Vial Quantity_____

Was a prior authorization obtained?

◯ Yes ◯ No Date PA submitted _____

If a PA was required or predetermination was recommended, please submit the PA or predetermination approval documentation with this request form.

For all claims, please provide the following:

- All claim EOBs
- Documentation of Any Prior Authorization Approvals and/or Appeal letters (if applicable)
- A copy of the claim forms (CMS 1500) for all claims and dates of service

*Please see the full Prescribing Information for AVOPEF™ including BOXED WARNING.
**Please see the full Prescribing Information for DOCIVYX® including BOXED WARNING.
***Please see the full Prescribing Information for FAVLYXA™ including BOXED WARNING.
****Please see the full Prescribing Information for KYXATA® including BOXED WARNING.

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Patient & Provider Information

Patient First Name _____ Patient Last Name _____ Patient Date of Birth _____

Address _____

City _____ State _____ Zip Code _____

Provider First Name _____ Provider Last Name _____ Provider Title _____

Contact Name _____

Contact Phone #_____ Contact Email _____

Facility/Account Name _____ Tax ID # _____ Fax Number _____

Physician NPI _____ Group NPI _____ PTAN/Payor Pin *(if applicable)* _____

Address _____

City _____ State _____ Zip Code _____

By signing below, I attest that, where required by applicable law, regulation, or other applicable authority, I have obtained patient consent, permission and/or a HIPAA authorization ("Legal Permission") permitting me to use and disclose my patient's health, demographic, and other individually identifiable information, including insurance information, to AVYXA®, its affiliates, its program administrator, and their respective agents, service providers and field reimbursement professionals for the purpose of providing patient support programs, co-pay assistance, and/or patient assistance, reimbursement support as part of the patient's treatment with an AVYXA® product. I maintain records of such Legal Permission consistent with applicable law. I further certify that (a) any reimbursement investigation support provided to patients through AVYXASSIST® is not made in exchange, directly or indirectly, for my recommendation, prescription, or use of the above therapy or any other product or service for or from anyone, and (b) my decision to prescribe the above therapy was based solely on my determination of medical necessity.

I hereby attest that my signature denotes that all facts and circumstances provided herin are true and accurate.

Prescriber (Name) _____ Date _____

Prescriber Signature _____