TOXO TOTAL CARE

ENROLLMENT FORM

OAKRUM PHARMA

PHONE: 1-833-TOXOMED (1-833-869-6633) | **FAX: 1-833-TOXOFAX** (1-833-869-6329)

○ New Patient ○ Current Patient

*Indicates required field. Please complete all required fields to avoid processing delays.

This form is intended for prescriber use only. Fax both pages of the completed form to **1-833-TOXOFAX**. (1-833-869-6329)

PATIENT INFORMATION

*Patient Name (Last, First):

*Date of Birth: Gender: M ☐ F ☐

*Address:

*City: *State: *Zip:

*Cell #: Alt. Phone #:

Email:

Preferred Contact Method: ☐ Phone ☐ Cell ☐ Email

Best Time to Call: ☐ Morning ☐ Afternoon ☐ Evening

Parent/Guardian (if applicable): ☐ Principal Contact

*Deliver to (choose one): ☐ Patient's Home

☐ Other (Print clearly): _____

PRESCRIBER INFORMATION

*Prescriber Name (Last, First):

Prescriber Practice Title:

MD Specialty:

*NPI #: Physician Medicaid UPIN #:

State License #: DEA #:

*Address:

*City: *State: *Zip:

*Phone #:

*Fax #:

*Staff Contact Name:

*Staff Contact #:

Staff Contact Email:

PATIENT INSURANCE INFORMATION/PHARMACY BENEFIT PLAN

Please complete the fields below or include a copy of the front AND back of the patient's prescription benefit and insurance card(s).

*Insurance: ☐ Commercial ☐ Government ☐ Uninsured

*Primary Insurance: Pharmacy Help Desk #:

*Policyholder Name: *Relationship to Patient:

*Member ID #: *Group ID #:

*Rx BIN #: *PCN #:

Secondary Insurance: Pharmacy Help Desk #:

Member ID #: Group ID #:

Rx BIN #: PCN #:

Special Instructions:

PATIENT DIAGNOSIS

*ICD-10 Code/Description:

*Please list any known allergies to medication or other substances:

PRESCRIPTION INFORMATION

*Patient Name (Last, First):

Drug: Pyrimethamine 25 mg tablets

*Quantity: *Refills:

*Directions:

*Start Date: Anticipated Duration:

Additional Prescription(s):

PROVIDER ATTESTATION

Prescriber signature must be the same as the prescriber name above

By signing below, I verify that the information being disclosed in this enrollment form is complete and accurate to the best of my knowledge. I understand that Oakrum Pharma, LLC ("Oakrum") reserves the right at any time and for any reason, without notice, to modify this enrollment form or to modify or discontinue any services or assistance provided through this Program. I have received the necessary legal authorization from the patient to disclose the patient's protected health information to Oakrum, Oakrum's designated administrator of the Program ("Administrator") and their respective affiliates, representatives, agents, and contractors, including any patient assistance program administrator(s), in connection with the Program, including but not limited to for purposes of verifying the accuracy of any information provided, verifying patient eligibility, and/or providing for payment and reimbursement. I authorize the Administrator to transmit prescribing information, by fax or other mode of delivery, to a pharmacy for fulfillment. I have prescribed pyrimethamine based on my professional judgment of medical necessity. Any medications supplied by Oakrum as a result of this form are for use by the named patient only and shall not be sold, traded, bartered, transferred, returned for credit, or submitted to any third-party payer (private or government) for reimbursement.

*Prescriber's Signature: *Date:

(No Stamps) (Dispense As Written)

*Prescriber's Signature : *Date:

(No Stamps) (Substitutions Permitted)

Please see accompanying Full Prescribing Information

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PATIENT REPRESENTATIVE (IF APPLICABLE)

Fax both pages of the completed form to **1-833-TOXOFAX** (1-833-869-6329).

By signing below, I authorize my Designee, listed below, to receive administrative information related to my treatment, such as appointment reminders, and to make decisions on my behalf–for which I will remain liable–regarding delivery of pyrimethamine 25 mg tablets. I acknowledge that neither Oakrum nor any of its affiliates, representatives, agents and contractors, including the Administrator, is liable for any decision(s) made by the Designee or actions taken in reliance on such Designee decisions.

Designee Name: _____ Relationship: _____ Phone# _____

Patient's Signature: _____ Date: _____

PATIENT AUTHORIZATION

I, or my authorized representative, hereby authorize the pharmacy receiving my referral or dispensing my medication, and its affiliates, representatives, agents, and contractors (collectively, "Pharmacy"), to use and disclose all of my individually identifiable health information; protected health information including but not limited to records that may contain information created by other persons or entities, including physicians and other health care providers, as well as information regarding the use of drug and alcohol treatment services, confidential HIV/AIDS treatment, mental health services (excluding psychotherapy notes), information about my medical condition, prescription, treatment, care management, and health insurance; and any other personal information, including all demographic information, email addresses, phone numbers, and other information, in the possession or control of Pharmacy (collectively "Information"), to Oakrum, the Administrator, and their respective affiliates, representatives, agents, and contractors, including any patient assistance program administrator(s), for pyrimethamine.

The Information may be used and disclosed for purposes of: (1) providing, coordinating, managing, and contacting me about, my prescriptions (including medication refill and adherence reminders), treatment, patient support, and other services related to my Oakrum products including providing information to the pharmacy dispensing my medication; (2) establishing my benefits eligibility, including for any financial or reimbursement support services offered by or on behalf of Oakrum; (3) communicating with me and my healthcare providers, health plans, and other payers about my medical care; and (4) providing me with information about current or future products or services.

I understand that Pharmacy may receive a fee from Oakrum in exchange for (1) providing me with certain materials and information described above, and (2) using or disclosing certain Information pursuant to this Authorization. I also understand that once my Information has been shared with Oakrum or the Administrator, it may be re-disclosed by Oakrum or the Administrator and no longer protected by the federal Privacy Rule. However, other state and federal laws may establish continuing protections for the disclosed information and prohibit Oakrum or the Administrator from disclosing specially protected information such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.

I understand that I may revoke this Authorization at any time, in writing, by sending written notification to the Administrator, 4060 Wedgeway Court, Earth City, MO, 63045. I understand that revoking this Authorization will prohibit disclosures of my information after the date the cancellation letter is received, but will not affect disclosures made by Pharmacy to Oakrum or the Administrator in reliance on this Authorization.

I understand that signing this Authorization is voluntary. I have the right to refuse to sign this Authorization and my refusal to sign will not affect my ability to obtain treatment or my eligibility for health plan benefits, and my Information will not be released. However, I understand that I will not have access to additional patient support, financial, or related services offered by Oakrum . This authorization expires December 31, 2099, or at an earlier date if required by state law. I understand that I have the right to receive a copy of this Authorization.

Patient or Authorized Representative Signature: _____ If Authorized Rep, State Basis for Authority: _____

Patient's Printed Name: _____ Date: _____

OAKRUM PHARMA

Please see accompanying Full Prescribing Information

March 2020 | PYR2020001
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