



# PATIENT SUPPORT REQUEST FORM

Phone: 1.800.288.8374  
Fax: 1.800.390.1826

PATIENT CHOOSES TO OPT-IN TO\*

Benefits Investigation†  \$0 Co-pay Program

## STEP 1 Patient Information

Required fields (\*)

Last Name*:	First Name*:	Date of Birth*:	Gender: <input type="radio"/> M <input type="radio"/> F
Street*:	City*:	State*:	ZIP*:
Home Phone: ( )	Cell: ( )	OK to Leave a Detailed Message? <input type="radio"/> Yes <input type="radio"/> No	
Email:	Preferred Language:	Preferred contact method:	
Alternate Contact's First and Last Name:	Relationship:	Alternate Contact's Phone: ( )	

## STEP 2 Patient Insurance Information (send in copy of insurance cards)

No Insurance

Patient's Medical Insurance*:			Telephone: ( )
Group Number:	BIN:	PCN:	Policy ID Number*:
Subscriber Name:		Date of Birth:	Relationship to card holder:
Patient's Pharmacy Insurance*:			Telephone: ( )
Group Number:	BIN:	PCN:	Policy ID Number*:
Subscriber Name:		Date of Birth:	Relationship to card holder:
Patient's Secondary Insurance*:			Telephone: ( )
Group Number:	BIN:	PCN:	Policy ID Number*:
Subscriber Name:		Date of Birth:	Relationship to card holder:

## STEP 3 Prescriber Information

Site/Facility Name:	Prescriber Name*:		
Street*:	City*:	State*:	ZIP*:
Telephone*: ( )	Fax*: ( )		
Office Contact Name:	Email:	Telephone: ( )	
Tax ID #:	NPI #:		

## STEP 4 Diagnostics Information

Has the patient tested positive for *NTRK* gene fusion?  
 Yes  No If yes, please provide lab test date: \_\_\_\_\_

If yes, please select test type:  
 Next-Generation Sequencing (NGS)  Fluorescence in situ hybridization (FISH)  
 Immunohistochemistry (IHC)†  Polymerase chain reaction (PCR)

†Following a positive TRK IHC test, confirmation of *NTRK* gene fusion is needed prior to initiation of VITRAKVI treatment.

## STEP 5 Prescription Information

**Prescribers in the state of New York:** Please submit prescriptions on official state prescription blanks in conjunction with this form.

**Must be NTRK gene fusion positive.**

ICD-10 Diagnosis Code(s) \_\_\_\_\_

Dosage Form\* VITRAKVI in:  25-mg capsule  100-mg capsule  20-mg/mL 100 mL bottle oral solution

SIG\* \_\_\_\_\_ Quantity\*: \_\_\_\_\_ Refills: \_\_\_\_\_

Known allergies: \_\_\_\_\_ Other medications: \_\_\_\_\_

I certify that the above therapy is medically necessary and that the information provided is accurate to the best of my knowledge.  
 I appoint TRAK Assist™, on my behalf, to convey this prescription to the dispensing pharmacy. I understand that I may not delegate signature authority.

## STEP 6 Prescriber Signature

PRESCRIBER SIGN, DATE, AND FAX TO 1.800.390.1826

Prescriber signature (required)\*: \_\_\_\_\_

Date\*: / /

# PATIENT HIPAA AUTHORIZATION

I voluntarily provide this authorization for the use and disclosure of my Protected Health Information (“PHI”), as such term is defined by the Health Insurance Portability and Accountability Act of 1996 (as amended, “HIPAA”). I understand that PHI is health information that identifies me or that could reasonably be used to identify me.

I authorize my healthcare provider, including my physician and pharmacy, and my health plan, to disclose to Bayer and its contracted agents my name, address, telephone number, health insurance status and coverage and such medical information as may be necessary for me to enroll in Access Services by Bayer™. I understand this disclosure(s) will contain PHI, including information about my current medical condition, treatment, coordination of treatment and receipt of medication. I allow the use and disclosure of my PHI to Bayer its contracted agents for the following purposes:

- To verify my insurance information and coverage
- To ensure the accuracy and completeness of the Access Services by Bayer™ Enrollment Form
- To help with my insurance coverage questions for Bayer medications
- To determine if I qualify for other Bayer patient support programs
- To determine my eligibility for other sources of prescription medication financial assistance
- To provide education, training, and ongoing support on the use of my Bayer medication
- To send me information on Bayer products and services related to my treatment
- To send me refill reminders for my Bayer prescription medication and to encourage its appropriate use
- To communicate with me, my healthcare providers and health plan about my medical care and treatment
- To contact me for market research feedback, sales support purposes, and as necessary to comply with applicable laws

I understand that:

- This Authorization will remain in effect until the end of my participation in Access Services by Bayer™ or 5 years from the date of my signature on this Authorization, whichever occurs later.
- I may cancel this Authorization at any time by writing to:  
**Access Services by Bayer, PO BOX 29097, PHOENIX AZ 85038-9097.**
- If I cancel this Authorization my healthcare provider and health plan will stop sharing my PHI with Bayer and its contracted agents. However, the revocation will not affect prior use or disclosure of my PHI in reliance on this Authorization.
- That entities that receive my PHI in accordance with this Authorization may not be required by law to keep the information private and that it will no longer be protected by the HIPAA privacy law. It may become available in the public domain.
- I do not need to sign this Authorization to receive (i) medical treatment or medication or (ii) coverage, payment, enrollment in or eligibility for benefits from my health plan. However, if I do not sign this Authorization, I may not participate in Access Services by Bayer™ or be eligible for other Bayer patient support programs.
- I understand that some of my health care providers, such as my pharmacies, may receive payment from Bayer in return for services that require use or disclosure of my PHI to Bayer and its contracted agents.

I have read and understand the terms of this Authorization and have had an opportunity to ask questions about the uses and disclosures of PHI. I understand that I am entitled to receive a signed copy of this Authorization and I can also get a copy by contacting Access Services by Bayer™ at 1-800-288-8374.

Patient name (print)\*: \_\_\_\_\_

Patient (or legal guardian) signature\*: \_\_\_\_\_

Date\*:        /        /

If signed by a legal representative: Print Name: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

PATIENT SIGN AND DATE

Please see Indication and full Important Safety Information on page 3 and click here for full [Prescribing Information](#).

\*Results of Benefit Investigation are not a guarantee of coverage and should be verified by dispensing provider.

