Cipla THERAPEUTICS
Division of Cipla USA, Inc.

Service Request Form

Call toll-free: 833-252-6266
Monday - Friday: 8:00 am to 5:00 pm, ET
Fax to: 833-252-6925

***Complete all required fields to avoid delay in processing.**

Patient Information

***Patient Name:**

***** ☐ **Male** ☐ **Female** | ***DOB:** / /

***Address:**

***City/State/Zip:**

***Home Phone:** ***Cell Phone:**

Preferred Phone: ☐ Home ☐ Cell

Email:

Language: ☐ English ☐ Spanish ☐ Other

Best Time to Contact: ☐ Morning ☐ Afternoon ☐ Evening

Insurance Information

Please include copy of front and back of patient's insurance card(s)

***Primary Insurance:** ***Policy ID#:**

Group #: Phone #:

Subscriber's Name: (if not self) Employer:

Secondary Insurance: Policy ID#:

Group #: Phone #:

Subscriber's Name: (if not self) Employer:

Prescriber Information

***Prescriber Name:** MD Specialty:

Practice Name: Office Contact:

***NPI #:** State Med Lic #:

Tax ID #: PTAN:

***Address:**

***City/State/Zip:**

Phone: Fax:

Email:

Program Options

***Select One:**

Benefit Investigation:	☐ Plazomicin 15 mg/kg	☐ Site of Administration
Prior Authorization Support:	☐ Plazomicin 15 mg/kg	☐ Site of Administration
Appeal Support:	☐ Plazomicin 15 mg/kg	☐ Site of Administration

Site of Administration

***Select One:** ☐ Outpatient Hospital
☐ Specialty Infusion Center
☐ Home Infusion
☐ Other: _____

***Name of Site/Agency:**

***Phone:** Fax:

***Address:**

***City/State/Zip:**

***NPI #:** Tax ID:

Contact Name: Phone:

Diagnosis and Clinical Information

***Diagnosis (Please indicate *ICD-10* Code):**

Currently taking plazomicin ☐ Yes ☐ No Start Date: / /

Directions:

Plazomicin injection for IV Infusion
Infuse____mg every day for_____days over_____minutes.

Dispense Quantity: ___vials, 500 mg in 10 mL (50 mg/mL) NDC 71045-010-01

Prescriber's Signature

By signing below, I certify that (a) the above-prescribed therapy is medically necessary and, (b) I have received from the patient identified above, or his/her personal representative, the necessary authorization to release, in accordance with applicable federal and state privacy laws and regulations, referenced medical and/or other patient information relating to the need for the above-prescribed therapy(ies), to Cipla Therapeutics, a division of Cipla USA, Inc. and its agents or contractors for the purpose of seeking information related to coverage for the therapy(ies) and/or assisting in initiating or continuing therapy.

➡ ***Prescriber's Signature:**
NO STAMPS PLEASE Date:

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Patient Authorization - IMPORTANT INFORMATION, PLEASE READ

I authorize my healthcare providers, pharmacies, health plans or payers ("my health care organizations") to share personal and health information about me related to my Cipla Therapeutics therapy ("my information") with Cipla Therapeutics, a division of Cipla USA, Inc, Inc., its affiliates, agents, and contractors (collectively, "Cipla Therapeutics"). I understand that once my information is shared with Cipla Therapeutics, my information may be protected by certain state privacy laws but not by federal health privacy laws redisclosed by Cipla Therapeutics. Cipla Therapuetics agrees to protect my information and to use and share it only for the reasons listed below. I authorize my health care organizations to share my information with Cipla Therapeutics, in order for Cipla Therapeutics to: (1) contact me or my health care organizations, or others I have identified, about my disease or treatment; (2) confirm my health plan eligibility and benefits, identify other payers for my therapy, or determine whether I may be eligible for assistance programs; (3) enroll me in Cipla Therapeutics therapy-related programs and provide therapy access support services; (4) perform analyses or improve or develop products, services, programs, or treatment related to my disease; (5) provide me by any means of communication, including by email, mail, or telephone (including voicemail) with information to educate or inform me about Cipla Therapeutics therapies and ways to help me maintain my prescribed treatment; and (6) use and disclose my information for safety reasons or as required by law. I understand that if I do not sign this form, I will still be eligible for health plan benefits and my treatment and payment for my treatment by my health care providers and pharmacy will not be affected, but I will not have access to the Cipla Therapeutics services and support described above.

This Authorization will expire 10 years from the date signed below unless a shorter period is required by the law of my state of residence. I may discuss the scope of my Authorization at any time by calling (833) 252-6400 and may cancel it by writing a letter saying I cancel my Authorization, and mailing it to Cipla Therapeutics, a division of Cipla USA, Inc., Attn: Market Access Team, 10 Independence Blvd, Suite 300, Warren, NJ 07059. My cancellation will not be effective until after Cipla Therapeutics receives it and my health care organizations are notified of it by Cipla Therapeutics, and it will not apply to prior actions taken by Cipla Therapeutics and my health care organizations based on this Authorization. I have a right to request and receive a copy of this Authorization in the same ways described above for cancellation.

*** Patient Name (Print):** Date:

⇨ ***Patient or Representative Signature:**
NO STAMPS PLEASE

***If this form is signed by someone who is not the patient listed, describe the signer's legal authority to act for the patient:**