Jazz Cares for Vyxeos™
Enrollment and Patient Authorization Form

Call Toll Free: 1-855-589-9367
Monday-Friday: 8:00 am to 8:00 pm, ET
Fax to: 1-877-256-2430
Jazzcares@jazzpharma.com

Patient Authorization on the back of this form must be signed by the patient to participate in Jazz Cares Program

Patient Information

Patient name:	
Male Female	DOB:
Address:	
City/State/Zip:	
Home Phone:	Cell Phone:
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:

Physician Information

Physician Name:	MD Specialty:
Practice Name:	Office Contact:
NPI #:	State Med Lic #:
Tax ID #:	PTAN:
Address:	
City/State/Zip:	
Phone:	Fax:
Email:	
Setting of Care: Physician's Office Outpatient Hospital Other (explain):	
Is doctor contracted with patient's insurance? Yes No	

Diagnosis & Clinical Information

Diagnosis (Please indicate ICD-10 Code):

ICD-10 Description:

Has this patient been diagnosed with newly diagnosed acute myeloid leukemia (t-AML) or acute myeloid leukemia with myelodysplasia-related changes (AML-MRC)? Yes No

Currently taking VYXEOS? Yes No | Start Date:

Treatment Information

Product Requested	Dose	Treatment Date(s)
VYXEOS		

Other Drug(s) prescribed with VYXEOS:

CPT Code(s):

Physician'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 Jazz Pharmaceuticals and its affiliates or vendors for the purpose of seeking information related to coverage for the therapy(ies) and/or assisting in initiating or continuing therapy.

Physician's Signature (NO STAMPS PLEASE):	Date:

*****Please complete the Patient Authorization on the back of this form.***

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Please Print

Prescriber Name

Patient Name

Patient Authorization ("Authorization")

(SIGNATURE IS REQUIRED FOR PARTICIPATION IN JAZZ CARES FOR VYXEOS)

I hereby authorize my prescriber(s) and their staff and my health insurer(s) to disclose my personal health information ("Personal Health Information" or "PHI") to Jazz Pharmaceuticals (including its affiliates and vendors who help provide the services) (together "Jazz Pharmaceuticals") for the Jazz Cares VYXEOS Program (the "Program").

I understand and authorize Jazz Pharmaceuticals to use the PHI it receives as a result of this Authorization for the following purposes: (i) enrolling me in the Program; (ii) verifying, investigating, coordinating and resolving insurance coverage or reimbursement inquiries and payment for VYXEOS; (iii) coordinating my receipt of and payment for VYXEOS; (iv) contacting me about the Program (this may include supplemental educational materials, information, offers and services related to my therapy or my medical condition, or opportunities to participate in focus groups, surveys or interviews); (v) contacting and providing my PHI to patient advocacy organizations, patient assistance programs, co-pay assistance or similar programs to determine eligibility for coverage and enrollment; (iv) de-identifying my PHI by aggregating it for research purposes, and (v) managing the Program.

I understand and authorize Jazz Pharmaceuticals to contact me through a variety of means including email, postal mail, phone, or fax, unless I opt out of these communications by contacting Jazz Pharmaceuticals using the contact information below.

I understand Jazz Pharmaceuticals will not disclose my Personal Information to a third-party that is not related to the Program (such as a family member or friend) unless I specifically authorize Jazz to do so. If I request that a person or an entity other than Jazz Pharmaceuticals receives my PHI, I understand the receiver may not be subject to HIPAA or other privacy laws and the PHI might be re-disclosed by the recipient and no longer protected by HIPAA or other privacy laws.

I understand I may refuse to sign this Authorization and my refusal will not affect the treatment I receive from my prescriber(s) and their staff, and my health insurer(s). I also understand that if I revoke this Authorization, I may no longer be eligible to participate in the Program. I understand I may revoke this Authorization at any time in the future except to the extent Jazz Pharmaceuticals has already taken action in reliance on this Authorization and my future revocation will not affect the treatment I receive from my prescriber(s) and their staff, and my health insurer(s); but if I revoke this authorization I may no longer be eligible to participate in the Program.

This Authorization will remain valid for five (5) years after the date of my signature unless a shorter time is required by state law. I can also revoke it earlier by calling 1-866-997-3688 or sending my request to Jazz Cares VYXEOS Program, 1 Tara Boulevard, Suite 200, Nashua, NH 03062. I also understand the Program may be changed or ended at any time without prior notification. I understand I may request a copy of this Authorization that is on file with Jazz.

I verify the information provided is true and correct. If I am the caregiver for the patient, I confirm I am authorized to sign on behalf of the patient.

Patient/Guardian Signature:

Date: