Sancuso®
(Granisetron Transdermal System)

Patient Enrollment Checklist

Customer Service/Live Support: **(844) 214-3442**
Fax completed form to: **(844) 214-3444**

patient Rx solutions

Overview

Easily enroll your patients into Patient Rx Solutions to help streamline their access to Kyowa Kirin products. This unique program provides real-time status reporting, the benefits of a dedicated team for reimbursement, assistance and the convenience of home delivery.

Patient Rx Solutions Services

Reimbursement Support
Benefits Verification
Prior Authorization and Appeals Support

Financial Assistance
Copay Card Program*
Patient Assistance Program*
Referrals to Third Party Independent Foundations

Other Services
Adherence Program
Patch Replacement Program*
Patch Price Guarantee*

Enrollment Checklist

- ☐ Fill out the enrollment form entirely
- ☐ Sign and date the "Provider Attestation" portion
- ☐ Include the patient chart notes and history
- ☐ Fill out and sign a letter of medical necessity**
- ☐ Fax all paperwork and this form to (844) 214-3444

Office Contact_____ Direct Line_____

Other Ways to Enroll

Call 844-214-3442 M-F 8am-8pm ET

E-Prescribe to ASPN Pharmacies
Florham Park, NJ 07932
NCPDP: 3147863
NPI: 1538590690

Visit the Physician Portal at
sancuso.aspnprograms.com

*For eligible patients only. Please go to www.patientrxsolutions.com for eligibility requirements
**Optional. Template can be found at www.patientrxsolutions.com

KYOWA KIRIN

Services Provided Through: ASPN Pharmacies,LLC
200 Park Ave, Suite 300 Florham Park, NJ 07932
Phone 973-564-8004 Fax: 973-564-8010

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Benefit Verification Form*

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(* Additional plan specific form may be required for Prior Authorization)

*Indicates required field

PRESCRIBER INFORMATION

*Prescriber Name (First, Last, Middle Initial):

*NPI #: DEA #: License #:

Phone #:

Fax #: Contact Email:

*Address Street/Suite:

*State: *Zip:

PATIENT INFORMATION

*Patient Name (First, Last, Middle Initial):

*Date of Birth: *Gender: M ☐ F ☐

*Address:

*State: *Zip:

*Phone #: Cell #:

Email:

*Deliver to: ☐ Patient's Home ☐ Physician's Office ☐ Fill at Preferred Pharmacy

If patient prefers a specific pharmacy, complete the fields:	*Pharmacy Name:		
Address:		City:	Zip:
Phone #:		Fax:	

PRESCRIPTION INFORMATION

*Patient Name (First, Last):

Drug: **SANCUSO®** (Granisetron Transdermal System) Date:

Dose: 1 Patch (3.1 mg/24H)

Number of Patches: Number of Refills:

*Sig (Directions):

Chemo is every ___ weeks

PATIENT INSURANCE INFORMATION

*Prescription Drug Insurer:

Policyholder Name: Relationship to Patient:

*Member ID #: *Group ID #:

*Rx BIN #: *PCN #:

Phone:

PRESCRIBER OFFICE CONTACT INFORMATION

*Office Contact Name (First, Last):

*Email: *Phone #:

PATIENT DIAGNOSIS

*ICD-10 Code/ Description:

Allergies:

Type of Cancer:

Rx's Failed, Dosage, Dates of Therapy and Reason for Failure:

PROVIDER ATTESTATION

By signing below, I certify that the information provided on this enrollment form is complete and accurate to the best of my knowledge and that this prescription is medically necessary for this patient. I understand that Armada Specialty Pharmacy Network (ASPN) may document modifications to the answers provided on this enrollment form so that the form reflects any updates or additional information necessary to ensure the answers provided are complete and accurate. I further understand that ASPN reserves the right at any time and for any reason, without notice, to discontinue any services or assistance provided through this Program. I certify that I have received the necessary authorization to release medical and/or other patient information relating to this prescription to ASPN, its affiliates, agents, representatives, and service providers, and for use and disclosure as necessary to determine the patient's benefits or enable the patient to receive the prescribed medicine. I further authorize ASPN as my designated agent to use and disclose the patient's protected health information as may be necessary for treatment, payment, and other health care purposes, including to verify the accuracy of any information provided, to confirm the patient's benefits and eligibility, and to permit payment and reimbursement. I further authorize ASPN to forward the above prescription information (by fax, electronically or otherwise) to a pharmacy for fulfillment. Finally, by checking the box below, I hereby consent and agree that ASPN is permitted to email me regarding prescription status updates. If I do not opt in to receive email updates from ASPN I understand I can call the customer service line to receive such updates.

☐ **Please send me status updates via email.** You may opt-in to receive e-mails from ASPN regarding the status of your patient's prescription. By agreeing to receive e-mails from ASPN, you acknowledge that ASPN will send standard e-mails to you via the Internet. Therefore, there is potential for these unencrypted emails to be intercepted by unauthorized third parties. If you share your e-mail account or computer with others, those parties may be able to access your confidential information. You should notify ASPN immediately if you wish to cease receiving e-mails or if your e-mail address changes. You should not use e-mails for emergencies.

*Prescriber's Signature

*Date of Signature

Signature is required to process the prescription. Stamped signatures are not permissible.

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