iwilfin® CARES

11001 Roosevelt Blvd. N, Suite 1400, St. Petersburg, FL 33716
Phone: (877) 494-5346, Option 1 **Fax:** (877) 291-9425

Referral Form

Patient Demographic Information

Patient Name: _____ DOB: MM / DD / YYYY Sex: ☐ M ☐ F

Mailing Address: _____ City: _____ State: _____ Zip: _____

SS#: ### / ## / #### Contact Person (if different from patient): _____ Relationship to Patient: _____

Home Phone: _____ Cell Phone: _____ OK to Leave Message: ☐ Yes ☐ No

Email: _____ Preferred Contact: ☐ Email ☐ Phone Best Time to Contact: ☐ AM ☐ PM

Language Preference: ☐ English ☐ Spanish ☐ Other _____

Patient Insurance Information — *Attach copies of both sides of patient's insurance card(s).*

☐ Check here if no insurance

Policy Holder Name: _____ Relationship to Patient: _____

Primary Insurance: _____ ID#: _____ Group: _____

Secondary Insurance: _____ ID#: _____ Group: _____

Pharmacy Plan: _____ ID#: _____ Rx BIN #: _____ Rx PCN #: _____ Group: _____

Is patient enrolled in any government, state or federally funded prescription benefit program? *(Medicare, Medicaid, Medigap, VA, DOD, Tricare)?* ☐ Yes ☐ No

Prescriber Information

First Name: _____ Last Name: _____ ☐ MD ☐ PA ☐ NP ☐ DO

State License #: _____ Expiration Date: MM / DD / YYYY

NPI #: _____ DEA: _____

Facility Name: _____

Facility Address: _____ City: _____ State: _____ Zip: _____

Office Contact: _____ Preferred Contact: ☐ Phone ☐ Email ☐ Fax

Office Phone: _____ Office Fax: _____ Email: _____

Patient Clinical Information

Primary Diagnosis: _____ **ICD-10:** _____

Drug Allergies: _____

Patient has demonstrated at least a partial response to prior multiagent, multimodality therapy including anti-GD2 immunotherapy: ☐ Yes ☐ No

Current Disease Status: ☐ CR ☐ PR ☐ Active Disease Relapsed/Refractory: ☐ Yes ☐ No Number of Relapses (if applicable): _____

Prescription

IWILFIN® (eflornithine) 192mg tablets (NDC 78670-150-01)

Dosing Instructions (select one):

- ☐ 768 mg (four tablets) orally twice a day (>1.5 m^2 BSA)
- ☐ 576 mg (three tablets) orally twice a day (0.75 to 1.5 m^2 BSA)
- ☐ 384 mg (two tablets) orally twice a day (0.5 to <0.75 m^2 BSA)
- ☐ 192 mg (one tablet) orally twice a day (0.25 to <0.5 m^2 BSA)
- ☐ Other _____

Dosing Weight (kg): _____ **Dosing Height** (cm): _____ **BSA** (m^2): _____

Dispense: QS for 30-day supply **Refills:** _____

Bridge or Quick Start Prescription* *(Optional - Insurance Required)*

IWILFIN® (eflornithine) 192 mg tablets (NDC 78670-150-01)

Dosing Instructions: _____

_____

_____

☐ *I authorize IWILFIN Cares to dispense to my patient up to two (2) 30-day supplies of IWILFIN if insurance determination is still pending after 15 days of receipt of referral. Bridge and Quick Start Prescriptions are at no cost to eligible patients within the labeled indication only, and is not contingent of a purchase of any kind.*

** The Bridge Prescription is intended to support continuation of prescribed therapy in the event of a delay in insurance coverage determination. The Quick Start Prescription is intended to support new to therapy patients in the event of a coverage delay. Neither the Bridge Prescription nor the Quick Start Prescription may be submitted for reimbursement to any third party payers. US WorldMeds® reserves the right to modify or terminate the program at any time without notice.*

Prescriber Authorization

By signing this Authorization, I certify that the person named on this form is my patient, and I represent that information I have provided about this patient is complete, accurate and consistent with applicable privacy laws and regulations. I also certify that any medication received from USWM, LLC (US WorldMeds) is medically necessary for the patient named on this form and will be used only for this patient. I further certify that the dose requested for this patient is appropriate for this patient's medical condition.

I understand that US WorldMeds and companies working with US WorldMeds, any of which may be branded as IWILFIN Cares may contact the applicant named in the Patient Information section for verification of applicant status and receipt of the indicated medication(s). I also agree to receive communications, including faxes, related to my patient's enrollment or participation in any of the IWILFIN Cares support programs.

SIGN HERE **Prescriber Signature** _____ **Date** _____

Original signature required. If this prescription form does not meet your state's prescription requirements, attach and fax a separate prescription or submit an electronic prescription,

Please see full Prescribing Information.

Please fax the completed Referral Form and copies of insurance card(s) to IWILFIN Cares at 1-877-291-9425