

Patient Demographic Information

Patient Name: _____ DOB: MM / DD / YYYY Sex: M F
 Mailing Address: _____ City: _____ State: _____ Zip: _____
 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 m² BSA)
- 576 mg (three tablets) orally twice a day (0.75 to 1.5 m² BSA)
- 384 mg (two tablets) orally twice a day (0.5 to <0.75 m² BSA)
- 192 mg (one tablet) orally twice a day (0.25 to <0.5 m² BSA)
- Other _____

Dosing Weight (kg): _____ Dosing Height (cm): _____ BSA (m²): _____

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,