

## **Specialty Pharmacy Enrollment Form**

**Find participating** specialty pharmacies at **BRIXADIHCP.com/access**and-support or by scanning the QR code.



INSTRUCTIONS: Please complete and fax both pages to the chosen specialty pharmacy participating in Braeburn's limited distribution network.

1 Patient Information									
First Name:		Last Name:			DOB: MM / DD / YYYY				
Address:		City:		State:	ZIP Code:				
Cell Phone:		Gender at Birth:	☐ Male ☐ Female	Email:	Email:				
Work/Home Phone:	Preferred Contact Method:  Text Call Email								
2 Patient Insurance Information									
Please fax a copy of both sides of the pa	tient's insurance (	card(s).							
Prescription Drug Insurer Plan:		Prescription Drug Insure	Phone:						
Member ID:	Rx Group #:		Rx BIN #:	F	Xx PCN #:				
Primary Medical Insurance:			Insurance Phone:						
Policy ID #:	Group #:		Medicare Beneficiary ID	#:					
Policyholder Name (First, Last):		Policyholder DOB:	F	Relationship to Patient:					
Secondary Medical Insurance:		Insurance Phone:							
Policy ID #:		Group #:							
Policyholder Name (First, Last):		Relationship to Patient:							
3 Patient Enrollment in the BRI	XADI Copay Sa	vings Program	(Optional: for commercially insur	ed, eligible patients o	nly)				
Patient is enrolled in the BRIXADI Copay			Copay ID #:						
4 Clinical Information (Ensure ICD-10 diagnosis code is provided)									
Scheduled Injection Date (if known): MM	/ DD / YYYY								
Primary Diagnosis (ICD-10 Code):									
Concomitant Medications:									
☐ Allergies:									

Because of the risk of serious harm or death that could result from intravenous self-administration, BRIXADI is only available through a restricted program called the BRIXADI Risk Evaluation and Mitigation Strategy (REMS).

NOTE: Prescriber must comply with his/her state-specific prescription requirements such as state-specific prescription forms, electronic prescribing requirements, product substitution or any other prescription element which may be required and that is not captured by this form. For this reason, the prescription form on page 2 should only be used if permitted by the applicable law in your state. The prescriber should include all required elements of a controlled substance prescription.





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Patient Name:							Patient DOB:				
Patient Addres	ss:										
5 Presci	riber Informat	tion									
Prescriber Name:							Prescriber NPI #:				
State License #: Li				Lice	License State:			Prescriber DEA #:			
Supervising Physician Name (if appropriate):				ı				Supervising Physician DEA #:			
Office Address:					City:						
State:		ZIP Code:		Phone:			Fa			Fax:	
Office Contact	Office Contact Name: Contact En			nail Address:					Office	Contact Phone:	
Facility Name: Practice NPI #:			Practice NPI #:	Facility Type:			Type: 🗌 Pro	rovider Office			
DEA Shipping	Address of Preso	criber (if different	from above):								
Shipping Loca	tion DEA # (if diff	ferent from above	):								
NOTE: BRIXA	DI orders canno	t be fulfilled unle	ess the shipping	addr	ess match	es the r	egistered ac	dress on	file with	n the DEA.	
6 Presci	ription Inform	ation									
	Strength, and Do										
Directions/Sig	g:										
Quantity (Numeric and Written):					Refills (Numeric and Written):				n):		
Primary Diagr	nosis (ICD-10 Co	ode):									
		ogistics of supply Ol supply to last 2					tinuity of ca	are (eg, un	anticipa	ated shipment delays). We recommend	
7 Presc	riber Certifica	ation									
BRIXADI base have obtained Act of 1996 an individually ide	d on my indepen my patient's writ nd its implementi entifiable health in	ident medical judo tten authorization ng regulations, ar nformation on this	gment that BRIXA in accordance wind ad the Substance is form to agents a	DI is th app Use I and se	medically i olicable sta Disorder Pa ervice prov	necessar ate and fe atient Red iders of E	y, and I will s ederal laws, i cords Regula Braeburn Inc	supervise to ncluding the ation (42 C . for benef	the patie ne Healt .F.R. Part its eligib	f my knowledge. I have prescribed ent's medical treatment. I certify that I h Insurance Portability and Accountability t 2), as amended to provide the illity, coverage authorization, and pecialty pharmacy.	
When require	d by law, send e	electronic prescri	ption or on offic	ial st	ate prescri	iption bl	ank.				
SICN	Prescriber		/ DD / YYYY								
SIGN	Signature Required*					Dispense as written					
*0:		Date: MM ,	DD / YYYY	_				Substitu	tion allow	ed	
*Signature stam	ps not acceptable.										

Please see the BRIXADI Full Prescribing Information, including Boxed Warning, at brixadihcp.com or accompanying this document.