Triptodur®
(triptorelin)
for extended release injectable suspension

TRIPTODUR CARE℠ BRIDGE PROGRAM

Customer Service: (833) 401-2273 | **Fax completed form to:** (855) 246-3986
Visit us: www.Triptodur.com

TRIPTODUR CARE BRIDGE PROGRAM ENROLLMENT FORM

*Indicates required field

Please attach insurance card image.

PATIENT INFORMATION

*Patient Name (Last, First):

*Date of Birth: *Gender: M ☐ F ☐

*Address:

*City: *State: *Zip

*Caregiver Name (Last, First):

Caregiver Email:

*Caregiver Phone: Secondary Number:

PRESCRIPTION SHIPMENT INFORMATION

TRIPTODUR should only be administered by a healthcare provider. Patient/Caregiver is responsible for bringing TRIPTODUR to their scheduled injection appointment.

☐ Patient Home ☐ Physician Office ☐ Other:

Shipping Contact Name:

Shipping Address (if different from above):

City:

State:

Zip:

PRESCRIPTION INFORMATION

Drug: **TRIPTODUR (triptorelin) 22.5 mg** Date:

Quantity: **1 Kit (22.5mg/2mL Injectable)** Refills:

Directions: **Inject 22.5mg intra-muscularly every 24 weeks**

Please attach insurance card images or clinical documents (optional)

Diagnosis Code(s):

Next date of therapy (if applicable):

Date(s) of prior treatments:

Product(s) used:
☐ **Lupron Depot-Ped 1mo** ☐ **Supprelin LA**
☐ **Lupron Depot-Ped 3mo** ☐ **Fensolvi**
☐ **Lupron Depot-Ped 6mo**

Patient Naive to GnRH therapy: ☐ Yes ☐ No

PHARMACY INSURANCE INFORMATION

*Insurance Name: Pharmacy Help Desk #:

Policyholder Name: *Relationship to Patient:

*Member ID #: *Group ID #:

*Rx BIN #: *PCN #:

MEDICAL INSURANCE INFORMATION

*Primary Insurance: *Phone:

*Member ID: *Group ID:

Secondary Insurance: Phone:

Member ID: Group ID:

Prescriber: ☐ In Network ☐ Out of Network

PRESCRIBER INFORMATION

*Prescriber Name (Last, First):

*NPI:

*Prescriber Phone: *Fax:

*Address:

*City *State: *Zip:

Email:

*Tax ID: *Medicaid Provider ID:

PRESCRIBER OFFICE CONTACT INFORMATION

*Office Contact Name (Last, First):

*Email: *Phone:

HEALTHCARE PROVIDER ATTESTATION

I understand that bridge approval is dependent on the prescriber's efforts to secure coverage, before and after bridge prescription is dispensed. I further understand that once bridge is approved, as the prescriber, I will continue efforts to get coverage and provide PA denial and appeal documentation to program.

I certify that I am the healthcare professional who has prescribed the therapy identified in this form. I further certify that I have made an independent judgment that the above therapy is medically necessary and that the Information provided in this form is accurate to the best of my knowledge. I further certify that any support provided through the Triptodur Care Bridge Program on behalf of any patient is not made in exchange for any express or implied agreement or understanding that I would recommend, prescribe, or use TRIPTODUR or any other Azurity product or service for anyone. I authorize Azurity, the Triptodur Care Program, and its affiliates, agents, representatives, and service providers to act on my behalf for the purposes of transmitting this prescription to the appropriate pharmacy.

***Prescriber's Signature**

***Date of Signature** (Dispense As Written)

Please see Important Safety Information available at **www.Triptodur.com** and the accompanying full **Prescribing Information**.

CONTINUE ➡

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HEALTHCARE PROVIDER CONSENT TO SHARE HEALTH INFORMATION & RECEIVE COMMUNICATIONS

By my signature, I certify that I have obtained any and all authorizations and consents from the patient or the patient's authorized personal representative necessary under HIPAA and state law to release protected health information, including that contained on this form, to Azurity Pharmaceuticals, Inc. and its employees or agents for purposes relating to Azurity Pharmaceuticals' patient support programs, including, assisting the patient with benefits verification, prior authorization/appeals assistance, financial assistance resources and information, such as copay support or free drug programs, for which the patient may be eligible, and other support for TRIPTODUR.

I certify that I have obtained consent from the patient or the patient's caregiver to be contacted by Azurity Pharmaceuticals, the Triptodur Care Bridge Program, and/or parties acting on their behalf using an autodialer or prerecorded voice at the telephone number(s) provided regarding the purposes described above and for other non-marketing purposes. I also give my permission to receive calls related to these services from Azurity Pharmaceuticals, the Triptodur Care Bridge Program, and parties acting on their behalf, including calls made with an autodialer or prerecorded voice at the phone number(s) provided.

***Prescriber's Signature** _____ ***Date of Signature** _____

PATIENT AUTHORIZATION

Authorization for Use and Disclosure of Protected Health Information

I authorize Azurity Pharmaceuticals, companies working with Azurity Pharmaceuticals, my healthcare provider and pharmacy to use and disclose to Azurity Pharmaceuticals, and companies working with Azurity Pharmaceuticals, my Protected Health Information ("PHI"), such as information provided on the TRIPTODUR CARE Bridge Program Patient Enrollment Form, my prescription, insurance, and medical therapy information. I authorize the disclosure of my PHI to specific individuals who are identified on the TRIPTODUR CARE Bridge Program Patient Enrollment Form. I understand that the companies working with Azurity Pharmaceuticals, including my pharmacy, may receive payment for the use and disclosure of my PHI. I understand that I do not have to agree to the use and disclosure of my PHI in order to receive TRIPTODUR. While my PHI will be protected and used and disclosed only for the intended purposes, I understand that once it is disclosed, it may be re-disclosed by the recipient(s). After such a disclosure, the information may no longer be protected by the terms of this authorization against further re-disclosure. I understand that I may revoke this authorization to use or disclose my PHI by contacting a Triptodur Care Program representative by telephone (833-401-2273) or by mailing a letter to Azurity Pharmaceuticals, Inc. 8 Cabot Road, Suite 2000 Woburn, MA 01801 Attn: Legal Department.

By signing below, I authorize the use and disclosure of my Protected Health Information as explained above. If you are signing this Authorization as a personal representative of the person to receive TRIPTODUR, please state your relationship (e.g., "mother," "father," "Legal Guardian").

*Print Patient Name:

*Print Name of Caregiver:

*Relationship to Patient:

***Caregiver's Signature:**

***Date of Signature:**

Terms and Conditions

- Patient and caregiver must be a United States (U.S) citizen or resident and must physically reside in the U.S or U.S territory.
- Patient has been prescribed Triptodur for an on-label, FDA-approved indication.
- Prescriber must complete and submit Bridge enrollment form to enroll patient in the program.
- Patient has insurance that has been delayed or denied and documented. Prior Authorization (PA) denial and appeal management documentation is required. Failure to include documentation may result in delays. This will be confirmed by the prescriber attestation on the Bridge application.
- Patient or provider cannot submit the value of the free product as a claim for payment to any third-party payer.
- Patient or provider must contact program if insurance changes or coverage becomes available, at any point during the program year.
- Program covers the cost of product only.
- No portion of the value of the free product will count towards the patient's applicable out-of-pocket cost-sharing obligations.

Azurity reserves the right to cancel or modify the program at any time.

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