ThyrogenONE®
Ordering and Reimbursement

Please FAX Form to: 1.888.326.1002 Phone: 1.88.THYROGEN (1.888.497.6436) www.thyrogen.com

Insurance Verification Form for Thyrogen® (thyrotropin alfa)

Entire form must be completed, and all required signatures obtained for form to be processed.

SECTION I: Requested (select one)

☐ Benefit Verification ☐ Benefit Verification & Specialty Pharmacy

SECTION II: Patient Information

First Name:	Middle Initial:	Last Name:	DOB:
Address:			
City:	State:	Zip Code:	
☐ OK to leave message	Home Phone #:	Cell/Work #:	

SECTION III: Insurance Information ☐ INSURANCE CARDS ATTACHED ☐ NO INSURANCE

Primary Insurance Name:	**Subscriber Name:**	**DOB:**
Policy #:	Group #:	Phone #:
Prescription Drug Card:	Group #:	Phone #:
Secondary Insurance Name:	**Subscriber Name:**	
Policy #:	Group #:	Phone #:
Prescription Drug Card:	Group #:	Phone #:

SECTION IV: Prescriber Information

Prescriber Specialty: ☐ Endocrinology ☐ Nuclear Medicine ☐ Surgery ☐ Other _____

Prescriber First Name:		Prescriber Last Name:		ThyrogenONE® ID #:
State License #:	NPI #:	Tax ID #:	DEA #:	BCBS Provider #:
Practice Name:		Phone #:		Fax #:
Practice Address:		City:	State:	Zip Code:

Site of Administration: ☐ Physician Office ☐ Hospital Outpatient ☐ Infusion Center

Reimbursement/Clinical Contact Name:	Title/Role:	
Phone #:	Email:	
Shipping Address (if different from Practice Address listed above):		
City:	State:	Zip Code:
Shipping Contact Name (if different from Reimbursement Contact listed above):	Phone #:	

SECTION V: Prescription Information

Rx Thyrogen® (thyrotropin alfa for injection) 0.9 mg vial, packaged 2 vials per kit. SIG - Administer 0.9 mg IM (intramuscular)

☐ ICD-10/Diagnosis Code: C73 ☐Other: _____	Dosage & Administration: ☐ Q24HR x 2 Doses ☐ Sterile Water for Injection	Procedure Type: ☐ Radioiodine Ablation ☐ Follow Up Testing: First Subsequent ☐ First ☐ Subsequent	First Thyrogen Injection Date:

If I have requested specialty pharmacy, I authorize ThyrogenONE® to forward the prescription information to the specialty pharmacy dictated by the patient's insurance in order to dispense Thyrogen to the above-named patient.

PRESCRIBER'S SIGNATURE:	**Date:**

Reminder: This form cannot be processed without the prescriber's signature, the prescriber's acknowledgement of the patient's HIPAA consent, and copies of patient insurance card(s) (if available).

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Section VI. OR Section VII. must be completed for this form to be processed:

SECTION VI: PHYSICIAN ATTESTATION – HIPAA CONSENT AND AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION	
To be completed by Prescriber who has obtained required patient authorizations: By completing and faxing this form, you represent that your patient is aware of the disclosure of their personal health information to Sanofi Genzyme and its agents or affiliates for the purpose of providing benefit verification and drug fulfillment. You acknowledge and agree that you have obtained appropriate patient authorizations and legal consents as may be needed for such disclosure to Sanofi Genzyme to be made, including as may be required pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). If you have not obtained the patient's consent or authorization to share the patient's personal health information with Sanofi Genzyme, then Section VIII. below must be completed and signed.	
PRESCRIBER'S SIGNATURE:	**Date:**

Note: Section VII does not need to be completed if Section VI has been signed by the Prescriber:

SECTION VII: P A TI EN T AUTHORIZATION TO RELEASE HEALTH INFORMATION	
To be completed by patient:	
I authorize my healthcare providers and staff to disclose to Sanofi Genzyme, and its affiliates and agents, health information about me, including patient-related information provided throughout this form and related to my medical condition, treatment with prescribed Sanofi Genzyme therapies, health insurance coverage, claims, and prescriptions (together, "My Information"). My healthcare providers, specialty pharmacies, and Sanofi Genzyme (including its agents and affiliates) may use and disclose My Information for the purposes of providing certain support services, including benefit verification and drug fulfillment. Once My Information has been disclosed to Sanofi Genzyme, I understand that federal privacy laws may no longer protect it from further disclosure. However, Sanofi Genzyme agrees to protect My Information by using and disclosing it only for the purposes authorized in this Authorization or as otherwise required by law. I understand that I may have certain rights under applicable data privacy laws regarding My information, including the right to access My information held by Sanofi Genzyme. For further information regarding these rights, please reference the Sanofi Genzyme's Global Privacy Policy at www.sanofi.com/en/our-responsibility/sanofi-global-privacy-policy. I understand that if I decline to sign this Authorization, it will not affect my eligibility to obtain medical treatment, my ability to seek financial assistance from other sources, or my insurance enrollment or eligibility for insurance coverage.	
PATIENT'S SIGNATURE:	**Date:**

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