

For internal use only:

CASE NO:

BLUE CARD

Reimbursement Support Form for Thyrogen[®] (thyrotropin alfa for injection)

PLEASE FAX FORM TO: **1.888.326.1002**

PHONE: 1.88.THYROGEN (1.888.497.6436)

www.thyrogen.com

Patient Information

LAST NAME:

FIRST NAME / MIDDLE INITIAL:

ADDRESS:

CITY / STATE / ZIP:

PRIMARY PHONE:

SECONDARY PHONE:

EMAIL:

DATE OF BIRTH:

SOCIAL SECURITY NO:

GENDER:

MALE FEMALE

DIAGNOSIS CODE:

193 OTHER:

Insurance Information NO INSURANCE

Please attach copies of both sides of all insurance and prescription drug card(s) (if available) or complete information below.

PRIMARY INSURANCE NAME:

SUBSCRIBER NAME:

SUBSCRIBER ID NO:

GROUP NO:

PHONE:

PRESCRIPTION DRUG CARD:

GROUP NUMBER:

SECONDARY INSURANCE NAME:

SUBSCRIBER NAME:

SUBSCRIBER ID NO:

GROUP NO:

PRESCRIPTION DRUG CARD:

GROUP NUMBER:

Prescriber Information

LAST NAME:

FIRST NAME:

THYROGEN ONE ID:

ADDRESS:

CITY / STATE / ZIP:

PHONE:

FAX:

OFFICE CONTACT NAME:

NPI NO:

TAX ID NO:

STATE LICENSE NO:

DEA NO:

BCBS PROVIDER NO (IF BCBS PATIENT):

PRESCRIBER SPECIALTY:

ENDOCRINOLOGY NUCLEAR MEDICINE
 SURGERY OTHER

SHIP TO ADDRESS:

PRESCRIBER (ABOVE) OTHER (BELOW)

SHIP TO NAME:

ADDRESS:

CITY / STATE / ZIP:

PHONE:

FAX:

Prescription Information

Rx Thyrogen[®] (thyrotropin alfa for injection) 1.1 mg vial, packaged 2 vials per kit. SIG - Administer 0.9 mg IM (intramuscular)

Q 24 HR x 2 DOSES

SUPPLIES NEEDED

PROCEDURE:

Tg/SCAN

Tg

ABLATION

ESTIMATED ADMINISTRATION START DATE:

 / /

Prescriber's Signature

Date

Consent: "I, the prescriber, verify that I have written patient consent to share medical information with ThyrogenONE for reimbursement purposes." Prescriber or Representative's Initials: _____

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