

Enrollment Form

Accredo

By EVERNORTH

Phone Number: 877-732-3431
Fax: 888-302-1028

Optum

Phone Number: 855-427-4682
Fax: 877-342-4596



SENDERRA
Specialty Pharmacy

Phone Number: 855-460-7928
Fax: 888-777-5645

ODOMZO® (sonidegib)

ALL SECTIONS (1-5) REQUIRED

1. Patient Information

First name _____ MI _____ Last name _____ DOB (MM/DD/YYYY) ____/____/____ Gender M F Other
Address _____ City _____ State _____ ZIP code _____
Cell phone # (____) _____ Home phone # (____) _____ Email address _____
Best time to contact: Morning Afternoon Evening Communication preference: Phone Email Mail OK to leave a detailed message

2. Patient Insurance Information

No insurance coverage **OR** Copy of the policyholder's insurance card(s) (front and back) is/are attached **OR** Complete the insurance information below
(include all insurance cards: commercial, Medicare, and/or secondary insurance and prescription card) (if you cannot copy the policyholder's insurance card[s]).
Primary insurance _____ Policyholder _____ Insurance carrier's phone # (____) _____
Member ID # _____ Group # _____ Rx BIN (**must fill in**) _____ PCN _____

3. Diagnosis and Clinical Information

Locally advanced basal cell carcinoma recurred following surgery, or not a candidate for surgery, and not a candidate for radiation? Yes No
Has your patient started therapy? Yes No
If Yes, how many capsules has the patient received? _____
What was the date of their first treatment? _____
What is the date of their next treatment? _____
Any known patient allergies? Yes No
If Yes, please add here _____
Is the patient taking other medication? Yes No
If Yes, please add here _____

4. Healthcare Provider Information

First name _____ Last name _____
Facility/practice name _____ Specialty _____
Practice address _____ City _____ State _____ ZIP code _____
Practice phone # (____) _____ Practice fax # (____) _____ NPI # _____ State license # _____ Tax ID # _____
Practice contact first and last name _____ Phone # (____) _____ Email address _____

5. Prescription Information (Provider to Complete)

ODOMZO® Prescription (Please attach your prescription if this form does not comply with your state laws)

Primary diagnosis (ICD-10-CM code): _____
 C44.91 Basal cell carcinoma

Prescribed dose ODOMZO® (sonidegib) capsules 200 mg

Quantity _____ # of refills _____

Prescriber Directions (Must check 1 box)

200 mg once daily on an empty stomach
 Other _____

Sign 1 below: (Required in IN, SC, AL, and WA)



Dispense as Written



OR

May Substitute

By signing below, I acknowledge that I have read and agree to the Provider Agreement on the back of this form.



Provider Signature



Date (MM/DD/YYYY)

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Noncompliance with state-specific requirements could result in outreach to the prescriber.



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