TOGETHER with TESARO™
Patient Resource Program

TOGETHER with TESARO™ Program Enrollment Application

Oral VARUBI® (rolapitant): Instructions for Prescriber

You have chosen to enroll your patient through our online enrollment service. This document has been automatically sent to TOGETHER with TESARO. Please save this with your patient files to refer to for future use.

If you have any questions, please call TOGETHER with TESARO at 1-844-2TESARO (1-844-283-7276) Monday through Friday (8 AM to 8 PM ET).

Services Requested for Patient

Coverage Support (Benefits Investigation, Prior Authorization Facilitation, and/or Appeals Support)

Financial Assistance (Co-pay Assistance Referrals or Patient Assistance Program)

Prescriber Information

Prescriber First Name: _____

Prescriber Last Name: _____

NPI #: _____

DEA #: _____

PTAN #: _____

Tax ID #: _____

Site/Facility Name: _____

Mailing Address: _____

City: _____

State: _____

ZIP: _____

Office Contact's Name: _____

Office Contact's Phone #: _____

Fax #: _____

Office Contact's Email: _____

Patient Information

Patient First Name: _____

Patient Last Name: _____

Sex: _____

Date of Birth: _____

Patient's Address: _____

City: _____

State: _____

ZIP: _____

Home Phone #: _____

Cell Phone #: _____

Email: _____

Alt. Contact Name: _____

Alt. Contact Relationship: _____

Alt. Contact Phone #: _____

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Clinical Information

Primary Diagnosis: _____

Primary Diagnosis ICD-10 Code: _____

Supportive Care Diagnosis: _____

Supportive Care ICD-10 Code: _____

Expected Chemotherapy Cycle Frequency: _____

Expected Chemotherapy Duration: _____

Prior Supportive Care Therapies: _____

Drug Allergies: _____

Target Start Date: _____

Notes:

Insurance Information

Medicare Medicaid Commercial/Private Other/Uninsured

Medical Insurance Plan

Primary Insurance: _____

Phone #: _____

Policy ID #: _____

Group #: _____

BIN: _____

PCN: _____

Policy Holder's Name: _____

Policy Holder's Relationship to Patient: _____

Policy Holder's Date of Birth: _____

Prescription Drug or Secondary Insurance Plan

Prescription Drug or Secondary Insurance: _____

Phone #: _____

Policy ID #: _____

Group #: _____

BIN: _____

PCN: _____

Policy Holder's Name: _____

Policy Holder's Relationship to Patient: _____

Policy Holder's Date of Birth: _____

Preferred Shipping location

Prescriber's Office

Patient's Address

Other Address:

Street: _____

City: _____

State: _____

ZIP: _____

TOGETHER with TESARO™
Patient Resource Program

Patient Assistance Program: Patient Financial Information

Annual Gross Household Income: $ _____

# of Household Members (Including Patient): _____

Healthcare Professional Policy and Consent

Healthcare Professional Name: _____

Healthcare Professional Signature: _____

Date: _____