Synribo® Enrollment Form

Rx International Pharmacy

Phone: (305) 221-1421
Fax: (305) 221-3275

Patient Information

patient: _____ ☐ male ☐ female **DOB:** _____ **SS#:** _____
last name, first name

address: _____
street city state zip

primary phone number: _____ ☐ cell **alternate phone number:** _____ ☐ cell

caregiver: _____ **caregiver phone number:** _____

allergies: _____ ☐ NKDA

Clinical Information

Primary Diagnosis/ICD-9: ☐ 204.12 ☐ 205.10 ☐ 205.12 ☐ 205.11 ☐ other (please specify): _____

Complete this section ONLY if you would like Rx International Pharmacy to initiate a prior authorization or appeal on your behalf:

		reason for discontinuation of therapy		
prior therapy	**resistance**	**intolerance (please specify)**	**other (please specify)**	**year of discontinuation**
☐ Gleevec®	☐	☐	☐	
☐ Sprycel®	☐	☐	☐	
☐ Tasigna®	☐	☐	☐	
☐ Other (please specify) _____	☐	☐	☐	

patient weight: _____ ☐ lbs ☐ kg date: _____ patient height: _____ ☐ inches ☐ cm BSA[1]: _____ m^2

[1]BSA calculator available at synribohcp.com

Prescription	**Directions**	**Quantity**	**Refills**
☐ Synribo® 3.5 mg (1 mL) single-use vial (prescriber office administration)	induction dosing ☐ Inject _____ mg Sub-Q BID for 14 days of a 28—day cycle	☐ _____ single-use vials	_____
	maintenance dosing ☐ Inject _____ mg Sub-Q BID for 7 days of a 28—day cycle	☐ _____ single-use vials	_____
☐ Synribo® _____ mg (1 mL) prefilled syringe[2] (patient home administration)	induction dosing ☐ Inject _____ mg Sub-Q BID for 14 days of a 28—day cycle	☐ _____ single-use vials[3]	_____
	maintenance dosing ☐ Inject _____ mg Sub-Q BID for 7 days of a 28—day cycle	☐ _____ single-use vials[3]	_____

[2] Pharmacy to coordinate shipment in accordance with drug stability (144 hours [6 days] after reconstitution)

[3] 1 vial = 1 prefilled syringe, unless the dose is > 3.5 mg (1 mL)

Prescriber + Shipping Information

prescriber (print): _____ office contact: _____

preferred method of contact: ☐ phone ☐ fax ☐ email preferred contact persons email: _____

ship to: ☐ patient ☐ office ☐ alternate: _____
street city state zip

office address: _____
(street, suite, city, state, zip)

phone: _____ fax: _____ NPI: _____ DEA: _____

prescriber's signature: _____ date: _____
I authorize Rx International Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

Insurance Information: please fax copy of insurance card (front + back)

Updated on 03/04/15