Solesta® Patient Enrollment Form

PO Box 3794 Chesterfield MO 63006

PATIENT ENROLLMENT FORM

Phone: 1-844-350-9656 **Fax:** 1-513-506-7361 **Hours:** Monday – Friday, 9:00 a.m. – 6:00 p.m. ET

PATIENT BENEIFITS TO BE INVESTIGATED (Check to Opt Out)
Leave unchecked to initiate a FULL INVESTIGATION into your patient's benefits, or check one of the following to:
☐OPT OUT of patient's Specialty Pharmacy Benefit Verification (Specialty Pharmacy ships Solesta to the physician's office)
☐OPT OUT of patient's Medical Benefit Verification (Physician buys Solesta and bills insurance – Buy & Bill)

PATIENT INFORMATION (Required)			
Patient Name:		Date of Birth:_____/_____/_____	
SCHEDULED INJECTION DATE:_____/_____/_____	Gender: ◯ M ◯ F	SSN/ID# (last 4 digits):	
Phone:	Cell:	Patient Email:	
Address:	City:	State:	Zip:

PATIENT INSURANCE INFORMATION (Attach a copy of insurance cards, if available). CHECK HERE IF UNINSURED ◯			
Medical Insurance:	Insurer Phone#:	Policy#:	Group#:
Plan:			
Policy Holder's Name:		Policy Holder's Date of Birth:_____/_____/_____	
Secondary Insurance:	Insurer Phone#:	Policy#:	Group#:
Plan:			
Policy Holder's Name:		Policy Holder's Date of Birth:_____/_____/_____	
Pharmacy Insurance:	Insurer Phone#:	Policy#:	Group#:
Plan:	Rx Bin:	Rx PCN:	
Policy Holder's Name:		Policy Holder's Date of Birth:_____/_____/_____	
Secondary Insurance:	Insurer Phone#:	Policy#:	Group#:
Plan:	Rx Bin:	Rx PCN:	
Policy Holder's Name:		Policy Holder's Date of Birth:_____/_____/_____	

PRESCRIBER, FACILITY & ADDRESS INFORMATION			
Prescriber First Name:	Prescriber Last Name:		
Prescriber Type/Specialty:	State where Licensed:	State License#:	
NPI #:	Tax ID #:	PTAN:	
Practice/Facility Name:	Facility Type: ◯ Physician Office ◯ Hospital Outpatient ◯ Hospital Inpatient		
Facility Address:			
City:	State:	Zip Code:	
Office/Primary Contact Name:	Title/Role:		
Office Contact Primary Phone #:	Primary Fax #:		
Email Address (Prescriber or Office Contact):			

Solesta® Patient Enrollment Form

PO Box 3794 Chesterfield MO 63006

PATIENT ENROLLMENT FORM page 2 of 2

Phone: 1-844-350-9656 **Fax:** 1-513-506-7361 **Hours:** Monday – Friday, 9:00 a.m. – 6:00 p.m. ET

Patient Name:_____ Date of Birth: _____

CLINICAL INFORMATION (Please provide clinical documentation)	
Primary ICD/Dx:	Secondary ICD/Dx:
CPT Code(s):	
Has the patient failed conservative therapy? ◯ Y ◯ N	

CLINICIAN CERTIFICATION AND CONSENT (Required) **- Information for Benefit Verification Only**

Directions: To be injected submucosally by physician

◯ **1st Treatment – 4 injections**
Dispense 1 Carton (Contains 4 – 1ml Syringes)

◯ **2nd Treatment – 4 injections**
Dispense 1 Carton (Contains 4 – 1ml Syringes)

By signing below, I verify that the information provided in this Solesta® Reimbursement Assistance Program Patient Enrollment Form is complete and accurate to the best of my knowledge. I understand that Solesta® reserves the right at any time and for any reason, without notice, to modify this Solesta® Reimbursement Assistance Program Patient Enrollment Form or to modify or discontinue any services or assistance provided through Solesta® Reimbursement Assistance Program. Finally, I authorize Palette Life Sciences and EVERSANA as my designated agents to use and disclose health information as necessary to verify the accuracy of any information provided, to provide reimbursement services through Solesta® Reimbursement Assistance Program and (as applicable) to assess my patient's eligibility for copay assistance. My patient has provided a signed HIPAA Authorization that allows me to share protected health information with Palette Life Sciences for purposes of the Patient Access Support Program.

CLINICIAN: ◯ I have read and agree to the terms detailed on this form.

Signature: ▶	Today's Date:_____/_____/_____

Solesta Reimbursement Assistance Program Patient Authorization Form

By signing below, I confirm that I have the patient's written consent to release to Palette Life Sciences Inc, and its representatives, agents, and contractors his or her protected health information ("PHI"), including but not limited to my patient's name, ss# (if provided), medical and pharmacy records, information relating to his or her medical condition, treatment, and health insurance, as well as all information provided on any prescription, as it relates to his or her treatment with Palette products for purposes of providing services offered by EVERSANA; including without limitation (1) financial support services, including benefit verifications, potential out-of-pocket costs, and eligibility for financial assistance and/or other patient assistance; (2) providing product support and services; (3) communicate and exchange PHI with my patient's health care providers, pharmacies, and health insurers for reasons related to the Program; (4) internal business purposes such as testing systems and processes; and (5) contacting my patient by mail, e-mail, text, telephone or any other alternative communication method he or she authorize.

Signature ▶	Today's Date:_/_____/_____