Pertzye®
(pancrelipase)
Delayed-Release Capsules

Containing Bicarbonate-Buffered Enteric-Coated Microspheres

Take advantage of our
Pertzye® Care Program

$0 OUT-OF-POCKET for Co-Pay and up to $1440 worth of savings for deductibles for eligible patients.*

Two easy ways to enroll your patients:

1 E-Scribe

- Locate and select Pertzye® dosage: 4,000, 8,000, 16,000 or 24,000.
- Locate and select:
  Transition Pharmacy, (Retail)
  Feasterville-Trevose
  PA, 19053
  NPI #: 1336325265
  NCPDP #: 3989603

2 Fax

- Complete Pertzye® Care form, provided by your DCI Representative.
- Fax completed form to Transition Pharmacy at 866-694-2555.
- Customer Service/Patient Advocate: 833-821-8185

When the Pertzye Care Program Patient Advocate communicates with your patient, they will:

- Review the prescription order process.
- Provide personalized assistance with their insurance coverage.
- Process any necessary co-pays, deductibles or other out-of-pocket expense.
- Verify delivery and shipping options.

*__Eligibility:__ Available to patients with commercial prescription insurance coverage for Pertzye®. Co-pay and deductible assistance is not available to patients receiving reimbursement under any federal, state, or government-funded insurance programs (for example, Medicare, Medicaid, TRICARE, Department of Defense, or Veterans Affairs programs) or where prohibited by law. Offer subject to change or discontinuance without notice. **This is not health insurance.**

DCI Digestive Care, Inc.
1120 Win Drive, Bethlehem, PA 18017-7059
Voice: 1-877-882-5950 | **Fax:** 610-882-0349 | **www.pertzye.com**

19001 | 02/2019

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Date: _ _ - _ _ - _ _ _ _
Month Day Year

Pertzye® Care Program

PHARMACY - ORDER FAX FORM
FAX TO: 866-694-2555
CUSTOMER SERVICE #: 833-821-8185

PATIENT INFORMATION

PLEASE INCLUDE A COPY OF FRONT & BACK OF PRESCRIPTION INSURANCE CARD

NAME:_____ DATE OF BIRTH:_____

CELL PHONE #:_____ ALTERNATE #:_____

ADDRESS:_____ APT/SUITE:_____

CITY:_____ STATE:_____ ZIP CODE:_____

EMAIL ADDRESS:_____

ANY KNOWN ALLERGIES:_____

PHYSICIAN INFORMATION

NAME:_____

DEA #:_____ NPI #:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____

PHONE #_____ FAX #:_____

OFFICE CONTACT:_____ CONTACT PHONE #:_____

PHYSICIAN EMAIL:_____

PRODUCT	INSTRUCTIONS	QTY	REFILLS	DIAGNOSIS CODE
☐ **Pertzye® 4,000**				
☐ **Pertzye® 8,000**				
☐ **Pertzye® 16,000**				
☐ **Pertzye® 24,000**				

PRESCRIPTION INFORMATION

I authorize Transition Pharmacy, LLC and its representatives to act as an agent to initiate and execute the insurance prior-authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time providing written notice to Transition Pharmacy, LLC.

Physician Signature:_____ **Date:**_____

For e-PRESCRIBING, please use the following information for processing requests through your system:

Name: Transition Pharmacy, LLC **Pharmacy type:** Retail
City: Feasterville-Trevose **State:** PA **Zip:** 19053
NPI #: 1336325265 **NCPDP #:** 3989603

There is no additional cost to the patient or physician for this service.

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PLEASE NOTE: PHARMACY LAW REQUIRES FAXED PRESCRIPTIONS TO BE SENT FROM A PRESCRIBER'S OFFICE ONLY. NO PRESCRIPTIONS FAXED BY PATIENTS WILL BE ACCEPTED

DCI Digestive Care, Inc.