

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:
Total Care Rx
223-10 Union Turnpike
Oakland Gardens, NY 11364

2 Fax

- Complete the Pertzye[®] Care form, provided by your DCI Representative.
- Fax the Pertzye[®] Care form to Total Care Rx at 718-504-7426.
- Customer Service/Patient Advocate: 718-762-7111 x 667

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.**



Delayed-Release Capsules Containing Bicarbonate-Buffered Enteric-Coated Microspheres

Date: ___ - ___ - ___
Month Day Year

Pertzye® Care Program

PHARMACY - ORDER FAX FORM

FAX TO: 718-504-7426

CUSTOMER SERVICE #: 718-762-7111 x 667

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
<input type="checkbox"/> Pertzye® 4,000				
<input type="checkbox"/> Pertzye® 8,000				
<input type="checkbox"/> Pertzye® 16,000				
<input type="checkbox"/> Pertzye® 24,000				

PRESCRIPTION INFORMATION

I authorize Total Care Rx 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 Total Care Rx.

Physician Signature: _____ Date: _____

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

Name: Total Care Rx Pharmacy type: Retail
City: Oakland Gardens State: NY Zip: 11364

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



1120 Win Drive
Bethlehem, PA 18017-7059
Voice: 1-877-882-5950
www.pertzye.com

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



Voice: 718-762-7111
Toll Free: 866-868-2579
223-10 Union Turnpike
Oakland Gardens, NY 11364
www.TotalCareRx.com