

Pertzye[®]
(pancrelipase) 
Delayed-Release Capsules

Containing Bicarbonate-Buffered Enteric-Coated Microspheres

Infant Starter ProgramSM



The Infant Starter ProgramSM offers your patients the opportunity to receive Pertzye[®] 4,000 or 8,000 **FREE OF CHARGE** from the date of enrollment until two years of age **OR** one year free—whichever is greater. Patients must be under the age of two in order to enroll in this program.

It's easy to enroll in this program. Complete the program enrollment form on the reverse side.

This program is offered on equal terms available to the general public, regardless of health insurance status, and is not tied to the provision of any other item or service reimbursed in whole or in part by a program under federal Title XVIII or a state health care program.



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

Date: ___ - ___ - ___
Month Day Year

___ New Enrollment
 ___ Currently Enrolled
 (please check one)

Infant Starter ProgramSM Enrollment Form

PHARMACY - ORDER FAX FORM
FAX TO: 718-504-7426
CUSTOMER SERVICE #:
718-762-7111 x 667

This program offers your patient the opportunity to receive Pertzye[®] 4,000 or 8,000 **FREE OF CHARGE** from the date of enrollment until two years of age **OR** one year free—whichever is greater. Patients must be under the age of two in order to enroll in this program. Upon receipt of this program enrollment form, Pertzye 4,000 or 8,000 will be sent directly to your patient.

Date: ___ - ___ - ___
Month Day Year

Rx ___ Pertzye[®] 4,000 or ___ Pertzye 8,000 (90 Day Supply) _____ # of REFILLS

Sig: _____

Dosage: Capsules per meal: _____ Capsules per snack: _____ Total Capsules per day: _____

Pertzye[®] 4,000 is available for G-Tube feeding.

PHYSICIAN SIGNATURE: _____ DATE: _____ NPI/DEA #: _____

PHYSICIAN INFORMATION

NAME: _____

DEA #: _____ NPI #: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE # _____ FAX #: _____

OFFICE CONTACT: _____ CONTACT PHONE #: _____

PHYSICIAN EMAIL: _____

PATIENT INFORMATION

NAME: _____ DATE OF BIRTH: _____

CELL PHONE #: _____ ALTERNATE #: _____

ADDRESS (NO PO BOX): _____ APT/SUITE: _____

CITY: _____ STATE: _____ ZIP CODE: _____

EMAIL ADDRESS: _____ ANY KNOWN ALLERGIES: _____

MEDICATIONS: _____

I hereby authorize Total Care Rx to enroll the above-named patient in the Pertzye[®] Infant Starter ProgramSM, sponsored by Digestive Care, Inc. (DCI). I understand that enrollment in this program enables the patient to receive FREE Pertzye[®] 4,000 product from the date of enrollment until two years of age or one year free—whichever is greater. Patients must be under the age of two in order to enroll in the Pertzye[®] Infant Starter ProgramSM. Pertzye[®] 4,000 will be provided by Total Care Rx. I understand that Total Care Rx may use the health information I provide for internal educational and/or marketing purposes and will only disclose certain health information to DCI as required by law to report any adverse drug events. Both Total Care Rx and DCI will maintain the confidentiality of patient information. Contact Total Care Rx at 1-866-868-2579 for questions. DCI reserves the right to withdraw or cancel this offer at any time without notice. I understand the Pertzye[®] Infant Starter ProgramSM is subject to the availability of products and does not constitute an entitlement.

Minor's Parent/Guardian/Guarantor Name (please print): _____

Parent/Guardian/Guarantor Signature: _____



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



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****