ZEVASKYN™ Enrollment Form



Fax Referral To: 1-855-297-1270 Phone: 1-888-280-1190

Address: 6020 Ave Roberto Sanchez Vilella Carolina, PR 00982 NCPDP: 4026325

Preferred Contact Methods:	DATIENT INFORM		c Simple Steps to S		ral	
Address: City, State, ZIP Code: Preferred Contact Methods: Phone (to primary # provided below) Text (to cell # provided below) Email (to email p Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone. Primary Phone: Atternate Phone: Email: Last Four of SSN: Primary Language: Primary Phone: Primary Language: Prescriber's Name: Prescriber's Name: Prescriber's Name: State License #: Primary Language: Prescriber's Name: Prescription and insurance cards with this form, if available (front a ls the Patient Insured? Prescription and insurance cards with this form, if available (front a ls the Patient Insured? Prescription Phartier's DOB: Relationship to Patient: Prescription Insurance: Policy Holder's DOB: Relationship to Patient: Prescription Phartier's Policy ID: Prescription Phartier's Policy ID: RX BIN #: RX PCN #: Prescription Phartier's Policy ID: RX BIN #: RX PCN #: Prescription Phartier's Policy ID: Prescription Phartier's		•	• •	•	Gend	er: Male Female
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Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone. Primary Phone: Alternate Phone:						nail (to email provided below
Email: Last Four of SSN: Primary Language: Parent/Caregiver/Legal Guardian Name (Last, First): Relationship to patient: PRESCRIBER INFORMATION Prescriber's Name: State License #: State License						
Email: Last Four of SSN: Primary Language: Parent/Caregiver/Legal Guardian Name (Last, First): Relationship to patient: PRESCRIBER INFORMATION Prescribler's Name: DEA #: Group or Hospital: City, State, ZIP Code: Phone: Fax Contact Person: Contact Person: Contact's Phone: SIMSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front a list the Patient Insured? Yes No is the Patient enrolled or eligible for Medicare/Medicaid? Yes No Policy Holder's Name: Policy Holder's DOB: Relationship to Patient: Policy Holder's Name: Policy Holder's DOB: Relationship to Patient: Prescription Insurance: Prescription Insurance: Prescription Plan Telephone: Prescription Plan Telephone: RX BIN #: RX PCN #: RX BIN #: RX PCN #: RX BIN #: RX PCN #: PRESCRIPTION PATIENT PRESCRIPTION PATIENT PRESCRIPTION PATIENT PRESCRIPTION PATIENT PRESCRIPTION INFORMATION STRENGTH PRESCRIPTION INFORMATION PRESCRIPTION INFORMATION STRENGTH DOSE PRESCRIPTION INFORMATION STRENGTH DOSE PRESCRIPTION INFORMATION STRENGTH DOSE PRESCRIPTION INFORMATION PRESCRIPTION INFORMATION STRENGTH DOSE PRESCRIPTION INFORMATION PRESCRIPTION INFORMATION STRENGTH DOSE PRESCRIPTION INFORMATION Ancillarly supplies and kits provided as new Please complete ZEVASKYN™ Single-dose, patient-specific, COL7A1 protein gene-modified cellular sheets Patient is interested in patient support programs STAMP SIGNATURE NOT ALLOWED Ancillarly supplies and kits provided as new Please complete ZEVASKYN™ Product Order Form and patient consent form. These forms can be accessed by calling Abeona Assist at 1-81 PRESCRIPTION Abecided as new Please complete ZEVASKYN™ Product Order Form and patient consent form. These forms can be accessed by calling Abeona Assist at 1-81 PRESCRIPTION Abecided as new Please complete ZEVASKYN™ Product Order Form and patient consent form. These forms can	Primary Phone:			Alternate Phone	:	
NPI #: DEA #: Group or Hospital: Address:	Email:		Last Fou	r of SSN:	Primary Langu	age:
Prescriber's Name: DEA #: Group or Hospital: Group or Hospital: City, State, ZIP Code: Phone: Fax Contact Person: Contact's Phone: Fax Contact Person: Contact's Phone: SINSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front a list the Patient Insured? Yes No Is the Patient enrolled or eligible for Medicare/Medicaid? Yes No Policy Holder's Name: Policy Holder's DOB: Relationship to Patient: Medical Insurance: Telephone: Policy Holder's DOB: Relationship to Patient: Medical Insurance: Prescription Plan Telephone: RX BIN #: RX PCN #: RX BIN #: RX PCN #: Policy ID: Patient Is enrolled in manufacturer copay assistance Diagnosis (ICD-10): Patient Clinical Information: Patient Clinical Information: Patient Clinical Information: Height: In/cm Weight: Ib/kg Prior therapy, treatment dates, and reason(s) for discontinuation: Patient Status: New to therapy Continuation of therapy; date of last treatment Prescription Information: Contact Person: Location: City: State: Zip Code: PRESCRIPTION INFORMATION PRESCRIPTION INFORMATION Strength Surgically apply topically as directed to affected wounds Patient is interested in patient support programs Stamp Skinature not allowed Ancillary supplies and kits provided as new Patient is interested in patient support programs Stamp Skinature not allowed Ancillary supplies and kits provided as new Patient is interested in patient support programs Stamp Skinature not allowed Ancillary supplies and kits provided as new Patient is interested in patient support programs Stamp Skinature not allowed Ancillary supplies and kits provided as new Patient is interested in patient su			st):	Relationship to p	atient:	
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INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front a is the Patient Insured?	NPI #: DEA	#: Group	or Hospital:			
INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front a is the Patient Insured?	Address:		0	City, State, ZIP Code:		
Is the Patient Insured?	Phone:	Fax	Contact Person:		Contact's	Phone:
Policy Holder's Name: Medical Insurance: Telephone: Policy ID: Group #: Prescription Plan Telephone: Policy ID: RX BIN #: RX PCN #: DIAGNOSIS AND CLINICAL INFORMATION Diagnosis (ICD-10): Stein the Clinical Information: Allergies: Prior therapy, treatment dates, and reason(s) for discontinuation: Treatment status: New to therapy Sontinuation of therapy; date of last treatment/_/ Needs by date: ZEVASKYN™ can only be obtained by an activated Qualified Treatment Center: Location: Contact Person: Location: State: ZEVASKYNN™ can only Information MEDICATION MEDICATION Single-dose, patient-specific, COL7A1 protein gene-modified cellular sheets Pelease complete ZEVASKYN™ Product Order Form and patient consent form. These forms can be accessed by calling Abeona Assist at 1-88						
Medical Insurance:						
Prescription Insurance:						
Policy ID: Group #: RX BIN #: RX PCN #: Check box if patient is enrolled in manufacturer copay assistance 2 DIAGNOSIS AND CLINICAL INFORMATION Diagnosis (ICD-10): Q81.2 Epidermolysis Bullosa Dystrophica Other: RDEB Diagnosis Confirmed Through Genetic Testing: Yes No Patient Clinical Information: Height: in/cm Weight: Ib./kg Prior therapy, treatment dates, and reason(s) for discontinuation: Treatment status: New to therapy Continuation of therapy; date of last treatment / Needs by date: ZEVASKYN™ can only be obtained by an activated Qualified Treatment Center: Contact Person: Location: City: State: Zip Code: State: Zip Code: State: Zip Code: State: Zip Code: Surgically apply topically as directed to affected wounds PRESCRIPTION INFORMATION STRINGTH						
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6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)	Please complete ZEVASKYN	[™] Product Order Form and	patient consent form. Th	ese forms can be acce	ssed by calling Abed	ona Assist at 1-855-ABEONA-1.
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CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution" ATTN: New York and Iowa providers, please submit elec	CA, MA, NC & PR: Interchange is	nandated unless Prescriber writes t	he words "No Substitution"	ATTN: New	York and Iowa provider	s, please submit electronic prescription

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty® Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

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Plan member privacy is important to us. Our employees are trained regarding the appropriate way to handle members' private health information.

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