VIBATIV®
(telavancin) for injection

Enrollment Form

Please complete the form, sign, and FAX to 1-855-847-9478. For assistance with any questions, call 1-855-847-9435, Monday through Friday from 8 AM to 7 PM Central Standard Time.

Services Requested

Please check all that apply: ☐ Benefits Verification ☐ Prior Authorization Assistance ☐ Claims Assistance ☐ Patient Assistance Program **(No Physician Signature Required)**

Patient Information

Last Name:	First Name:
Address:	City: State: ZIP Code:
Date of Birth:	Gender: ☐ Female ☐ Male
Primary Phone: ( )	Secondary Phone: ( )
E-mail:	
Alternate Contact Name:	Phone: ( ) Relationship to Patient:

Insurance Information (please attach copy of front and back of insurance card[s])

PRIMARY Insurance Name:	SECONDARY Insurance Name:
Phone:	Phone:
Policy ID#:	Policy ID#:
Group #:	Group #:
Policyholder Name:	Policyholder Name:
Policyholder Date of Birth:	Policyholder Date of Birth:
Relationship to Patient:	Relationship to Patient:

Diagnosis and Treatment

Patient diagnosis including code:
PTAN (just for Medicare):
Procedure Code (for Medicare/Medicaid):
Site of Administration for Dose:
Administering Physician for Dose:
J Code:

Physician Information for Second Dose

Prescriber's First Name:	Prescriber's Last Name:	
Practice / Facility Name:	Specialty:	
Address:	City: State: ZIP Code:	
Office Contact Name:	Phone: ( )	Fax: ( )
Prescriber Tax ID:	Prescriber NPI:	Group NPI:

Site of administration: ☐ Physician's office ☐ Hospital outpatient ☐ Free-standing Infusion Clinic ☐ Other: _____

Specialty Pharmacy

Are you interested in acquiring medication through a specialty pharmacy? ☐ Yes ☐ No
If yes, please list any preferred specialty pharmacies:

Physician Declaration (signature required for all services except Patient Assistance Program)

I certify VIBATIV® is medically necessary and is being prescribed for the patient listed above based on my independent clinical judgment. I have supplied the program operated by Sonexus, an agent of Theravance BioPharma Inc., this information in order for them to coordinate access to treatment for my patient. I certify that the patient named above has authorized the release and disclosure of the information contained within this enrollment form for the purposes of investigating and resolving insurance coverage, coding or reimbursement questions. Should this patient qualify for free product through the program, I acknowledge and agree not to submit a claim for payment to the patient any third-party payor for the medication received. Nor will the medication received be resold or offered for sale, trade or barter and will not be returned for credit.

Physician Signature (no stamps):	**PHYSICIAN Sign Here**
Name (print):	
Date:	

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