Synribo® Enrollment Form

Employee Owned Thrifty White PHARMACY Specialty Services
toll-free phone 855.611.3399
toll-free fax 855.423.8300

Patient Information

patient: _____ ☐ male ☐ female **DOB:** _____ **SS#:** _____
last name, first name

address: _____
street city state zip

primary phone number: _____ ☐ cell **alternate phone number:** _____ ☐ cell

caregiver: _____ **caregiver phone number:** _____

allergies: _____ ☐ NKDA

Clinical Information

Primary Diagnosis/ICD-10: ☐ C91.12 ☐ C92.10 ☐ C92.11 ☐ C92.12 ☐ other (please specify): _____

Complete this section ONLY if you would like Thrifty White Pharmacy to initiate a prior authorization or appeal on your behalf:

reason for discontinuation of therapy

prior therapy	resistance	intolerance (please specify)	other (please specify)	year of discontinuation
☐ Gleevec®	☐	☐	☐	
☐ Sprycel®	☐	☐	☐	
☐ Tasigna®	☐	☐	☐	
☐ Other (please specify) _____	☐	☐	☐	

patient weight: _____ ☐ lbs ☐ kg date: _____ patient height: _____ ☐ inches ☐ cm BSA[1]: _____ m^2

[1]BSA calculator available at synribohcp.com

Prescription Information	directions	quantity	refills
☐ Synribo® 3.5 mg (1 mL) single-use vial (prescriber office administration)	induction dosing ☐ Inject _____ mg Sub-Q BID for 14 days of a 28—day cycle	☐ _____ single-use vials	_____
	maintenance dosing ☐ Inject _____ mg Sub-Q BID for 7 days of a 28—day cycle	☐ _____ single-use vials	_____
☐ Synribo® _____ mg (1 mL) prefilled syringe[2] (patient home administration)	induction dosing ☐ Inject _____ mg Sub-Q BID for 14 days of a 28—day cycle	☐ _____ single-use vials[3]	_____
	maintenance dosing ☐ Inject _____ mg Sub-Q BID for 7 days of a 28—day cycle	☐ _____ single-use vials[3]	_____

Thrifty White Pharmacy to coordinate shipment in accordance with drug stability (144 hours [6 days] after reconstitution)

[3] 1 vial = 1 prefilled syringe, unless the dose is > 3.5 mg (1 mL)

Prescriber + Shipping Information

prescriber (print): _____ office contact: _____

preferred method of contact: ☐ phone ☐ fax ☐ email preferred contact persons email: _____

ship to: ☐ patient ☐ office ☐ alternate: _____
street city state zip

office address: _____
(street, suite, city, state, zip)

phone: _____ fax: _____ NPI: _____ DEA: _____

prescriber's signature: _____ date: _____

I authorize Thrifty White Specialty Pharmacy 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 by providing written notice to Thrifty White Specialty Pharmacy.

Insurance Information: please fax copy of insurance card (front + back)