US Bioservices
AmerisourceBergen

Balversa™ Referral Form

Phone: (877) 757-0667
Fax: (888) 899-0067

Deliver to:

☐ Patient's Home ☐ Prescriber's Office ☐ Other:_____ ☐ Hold shipment until notified by prescriber ☐ Anticipated Start Date:_____

1. Patient Information

Patient's Name (last, first):_____
Address:_____
City:_____ State:_____ Zip:_____
Sex: ☐ Male ☐ Female Date of Birth:_____
Home Phone:_____ Mobile Phone:_____
Email:_____

Preferred Language:_____
Best time to reach me: ☐ Morning ☐ Afternoon ☐ Evening
OK to leave message? ☐ Yes ☐ No
Authorized Representative:_____
Relationship to Patient:_____
Phone Number (Authorized Representative):_____

2. Insurance Information (Please fax front and back copy of all insurance cards - prescription & medical)

Prescription Drug Insurer:_____
ID #:_____ Phone:_____
Group #:_____ BIN #:_____ PCN #:_____
Primary Medical Insurance:_____
Cardholder's Name:_____
Relationship to Cardholder: ☐ Self ☐ Spouse ☐ Child ☐ Other:_____
ID #:_____ Group #:_____ Phone:_____

Secondary Medical Insurance:_____
Cardholder's Name:_____
Relationship to Cardholder: ☐ Self ☐ Spouse ☐ Child ☐ Other:_____
ID #:_____ Group #:_____ Phone:_____

☐ **Patient does not have insurance**

3. Prescriber Information

Practice Name (last, first):_____
Prescriber Name:_____
Address:_____
City:_____ State:_____ Zip:_____
License #:_____
DEA #:_____ NPI #:_____

Phone:_____ Fax:_____
Email:_____
Office Contact:_____
Office Contact Phone:_____
Collaborating Physician:_____
DEA #:_____ NPI #:_____

4. Clinical Information (Please fax recent clinical notes, labs and tests, with the prescription to expedite the prior authorization)

Primary ICD-10:_____
Patient's current weight:_____ lbs Date:_____
Known Allergies:_____
Concurrent Medications:_____
_____

Patient FGFR positive? ☐ Yes ☐ No
Patient pregnant? ☐ Yes ☐ No
Patient breastfeeding? ☐ Yes ☐ No
History of eye problems? ☐ Yes ☐ No
Has patient scheduled or completed a baseline eye exam? ☐ Yes ☐ No

5. Prescription Information

Medication	Dose/Strength	Directions	Quantity	Refills
BALVERSA™ (erdafitinib)	**Initial Dosing:** ☐ 4 mg tablet	• Take 8 mg (two 4 mg tablets) PO once daily with or without food		0
	Maintenance Dosing: ☐ 3 mg tablet ☐ 4 mg tablet ☐ 5 mg tablet *Serum phosphate (PO_4) levels should be assessed between 14 and 21 days after initiating treatment.	☐ Take 9 mg PO once daily with or without food ☐ Take _____ mg PO once daily with or without food		

Prescriber Authorization (No stamps. Signature and date must be completed in prescriber's handwriting. NY prescriptions must be submitted via e-script.)

I authorize US Bioservices to act on behalf of myself and my patient to initiate any de minimus authorization process from health plans including the submission of any necessary forms to such health plans.

Prescriber Signature - Substitution Permissible _____ PRESCRIBER SIGNATURE REQUIRED. NO STAMPS. Date ____/____/____

Prescriber Signature - Dispense as Written _____ PRESCRIBER SIGNATURE REQUIRED. NO STAMPS. Date ____/____/____

(Please see full prescribing information before prescribing BALVERSA™)