

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

5. Prescription Information

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