APPLICATION TO REQUEST BENEFIT VERIFICATION ASSISTANCE

Website: www.astellaspharmasupportsolutions.com
Phone: 1-800-477-6472 **Fax:** 1-866-317-6235
Address: PO Box 501847, San Diego, CA 92150 **Hours:** Monday–Friday from 9 AM–8 PM ET

To request benefit verification for your patient, please complete the form and fax it to Astellas Pharma Support Solutions℠ at 1-866-317-6235.

PRODUCT

Myrbetriq® (mirabegron extended-release tablets)

PRESCRIBER INFORMATION

Prescriber Name: _____

NPI #: _____ State License #: _____ Tax ID #: _____

Facility/Practice Name: _____

Facility Address: _____

Contact Person: _____

Phone #: _____ Fax #: _____

PATIENT INFORMATION

Patient Name: _____ Sex: ___Male ___Female

Address: _____ City: _____ State: _____ Zip: _____

Daytime Phone #: _____ Date of Birth: _____

CURRENT INSURANCE INFORMATION

Patient Insurance Policy 1:

Medicare Part B **Medicaid** **Private/Commercial***
*includes Medicare Advantage

Policy Name: _____
Subscriber Name: _____
Subscriber ID #: _____
Telephone: _____
Effective Date: _____

Patient Insurance Policy 2:

Medicare Part B **Medicaid** **Private/Commercial***
*includes Medicare Advantage

Policy Name: _____
Subscriber Name: _____
Subscriber ID #: _____
Telephone: _____
Effective Date: _____

Patient Prescription Insurance:

Medicare Part D **Private/Commercial**

Insurer/PBM Name: _____
Telephone: _____
Subscriber ID #: _____
Subscriber Name: _____

PRESCRIBER CERTIFICATION AND CONSENT FOR ASTELLAS PHARMA SUPPORT SOLUTIONS

I hereby attest that I am the prescribing healthcare provider and that the Astellas medicine I prescribed to this patient is medically appropriate and I have explained such to my patient. I certify that the patient provided my office with the necessary authorization to release the protected health information (as defined by the Health Insurance Portability and Accountability Act [HIPAA] of 1996) referenced in the application submitted to Astellas Pharma Support Solutions℠ (APSS) for the purpose of APSS performing general reimbursement support. This consent authorizes Astellas through APSS, its third-party administrator, APSS agents and other representatives to contact the patient's insurer and disclose the following information: patient's name, date of birth, diagnosis, insurance information, or other information to the insurer. In turn, the insurer may transfer such information back to APSS. APSS will use this information for the purpose of providing general reimbursement support; however, the individuals contacted may release this information without APSS's knowledge. I certify that the information regarding the patient, including prescription insurance status, is accurate to the best of my knowledge.

I acknowledge I may be contacted by email, postal mail, or fax using the information I've provided, and I understand my personal information will be used and disclosed by Astellas in accordance with Astellas' privacy policy, available at www.astellas.com/us/privacy-policy.

***My signature below indicates that I have read, understand, and agree to the prescriber certification statement above, and I certify that the patient provided my office with written consent and authorization to proceed with this research.**

Prescriber's original signature* (stamps not accepted) _____ **Date:** _____

FOR FULL PRESCRIBING INFORMATION SEE WWW.MYRBETRIQHCP.COM OR CONTACT ASTELLAS MEDICAL INFORMATION AT 1-800-727-7003.