



APPLICATION TO REQUEST BENEFIT VERIFICATION ASSISTANCE

Website: www.astellaspharmasupportsolutions.com

Phone: 1-800-477-6472 Fax: 1-866-317-6235

Address: P.O. Box 13185 La Jolla, CA 92039 Hours: Monday – Friday from 9 AM – 8 PM ET

To request benefit verification for your patient, please complete the form and submit it to Astellas Pharma Support SolutionsSM eService or fax it to 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 SolutionsSM (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.

***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.