

# Completing the Patient Information Form

## 1 Patient information

It's essential that the patient's personal information is accurate.

## 2 Insurance coverage

You can either fill out the insurance information **OR** check this box and submit a copy of the patient's insurance card.

## 3 Patient's signature/notification

Have patient sign the form. If the form is not signed, Helpline staff will contact the patient directly for permission to proceed. Also, if the patient wishes to be contacted on the status of their claim, please check the notification box.

## 4 Diagnosis

For what medical condition is the patient being treated?

## 5 ICD-9


What is the ICD-9 code associated with this disease state?

## 6 Previous treatments

If patient has been treated for this condition before, what medications were used and what was the outcome?

## 7 Regimen

What is the complete dosing regimen to treat the condition?



**Phone: 1-800-444-DRUG**  
1-800-444-3784  
www.IBDhelpline.com

**PATIENT INFORMATION FORM**

**Please fax completed Form to: 800-387-5807**

Doe	John	P	M	123-45-6789	08/06/1969
<small>Last Name</small>	<small>First</small>	<small>M.I.</small>	<small>Male/Female</small>	<small>Social Security Number</small>	<small>Date of Birth</small>
123 First Avenue	Anytown	VA		20000	555-555-5555
<small>Street Address</small>	<small>City</small>	<small>State</small>		<small>Zip Code</small>	<small>Home Telephone</small>

**2 Primary Insurance**

UHC

Company Name \_\_\_\_\_

800-555-5555

Telephone \_\_\_\_\_

H1234567

Policy ID \_\_\_\_\_

Copy of insurance card attached

Please notify me (the patient) of research results

I authorize the Reimbursement Helpline to have access to all medical and insurance coverage information and records which pertain to the patient listed on this form, necessary to verify and/or obtain insurance coverage for Apriso. I further understand that all information and documentation will be held in strict confidence by the Reimbursement Helpline and will not be shared with any third party except in summary format, after verification of coverage.

<i>John P. Doe</i>	12/22/09
<b>Patient Signature</b>	<b>Date</b>

**Patient Medical Information**

4 Primary diagnosis: Ulcerative Colitis	5 ICD-9 code (required): 556.9
6 Previous treatment(s): Other therapies	
7 Apriso Regimen Prescribed (required): 4 capsules QD as directed	

**Physician Information**

Practice Name: Gastroenterology Associates	Tax ID #: 99-9999999
Address: 1111 First Avenue, Suite A Anytown, VA 20000	
Fax #: 555-555-5555	
<i>Jane Smith, MD</i>	2/4/09
<b>Physician Signature</b>	<b>Date</b>
Dr. Jane Smith	Nurse
Physician Name (Please Print)	Office Contact
	Telephone #

MCOGM 08/10

## 8 Physician/Practice information

The physician must sign and date this form in order for it to be valid for submission.

**IBD Reimbursement Fax Line: 1-800-387-5807**

APRISO is a locally acting aminosaliclylate indicated for the maintenance of remission of ulcerative colitis in patients 18 years and older. APRISO is contraindicated in patients with hypersensitivity to salicylates, aminosaliclylates, or to any of the components of APRISO capsules.

The recommended dose of APRISO is four 0.375-g capsules once daily in the morning (1.5 g/day) with or without food. Because dissolution of the coating of APRISO granules depends on pH, APRISO should not be coadministered with antacids. Patients with phenylketonuria should be aware that APRISO contains aspartame, equivalent to 0.56 mg of phenylalanine.

In 2 well-controlled clinical trials, the most common treatment-related adverse events occurring in at least 3% of adult patients taking 1.5 g/day of APRISO were headache (11% vs 8% for placebo), diarrhea (8% vs 7% for placebo), upper abdominal pain (5% vs 3% for placebo), nausea (4% vs 3% for placebo), nasopharyngitis (4% vs 3% for placebo), influenza and influenza-like illness (4% vs 4% for placebo), and sinusitis (3% vs 3% for placebo).