Support Request Form

CTI Access™
CTIaccess.com

Please complete this form based on the support you are requesting.
If you'd like to complete and submit your request electronically, please visit our website.

We are here to assist you Monday - Friday from 8 am to 8 pm EST.
Phone: 888-CTI-FORU (888-284-3678) | Fax: 888-284-8084 | Website: CTIaccess.com | Email: CTIaccess@rxallcare.com

PERSONAL INFORMATION

Submitter Information (REQUIRED for all requests)

First Name _____ Last Name _____ Title _____

Facility/Office Name _____ Phone# _____ Fax# _____

Email Address _____ Preferred Method of Communication: ☐ Phone ☐ Fax ☐ Email

Are you the contact if clinical documentation/additional information is needed? ☐ Yes ☐ No (if no, please confirm who is below)

Name and contact information _____

Patient Information (REQUIRED for all requests)

First Name _____ Last Name _____ DOB _____

Gender ☐ Male ☐ Female ☐ Other (please provide for identification purposes)

Street Address _____ City _____

State _____ ZIP _____ Phone# _____ ☐ Mobile ☐ Home

Email Address _____ Representative/Caregiver Name _____

Relationship to Patient _____ Phone# _____ ☐ Mobile ☐ Home

Email Address _____

BENEFITS INVESTIGATION

Primary Insurance (REQUIRED for all requests)

(Please attach a front and back copy of the insurance card if available.)

☐ **Please see attached front and back copy of the insurance card**

Insurance Carrier Name _____ Employer/Issuer (if available) _____

Phone# _____ Suffix# _____ ID# (to inc. prefix) _____ Group# _____

Prescription Carrier Name _____ Bin# _____ PCN# _____

Is this a Medicare Policy? ☐ Yes ☐ No Is this a Medicaid Policy? ☐ Yes ☐ No

Secondary Insurance (Please attach a front and back copy of the insurance card if available.)

☐ **Please see attached front and back copy of the insurance card**

Insurance Carrier Name _____ Employer/Issuer (if available) _____

Phone# _____ Suffix# _____ ID# (to inc. prefix) _____ Group# _____

Prescription Carrier Name _____ Bin# _____ PCN# _____

Is this a Medicare Policy? ☐ Yes ☐ No Is this a Medicaid Policy? ☐ Yes ☐ No

Please send completed forms and supporting clinical documentation to CTI Access™ via fax at 888-284-8084 or via email at CTIaccess@rxallcare.com

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PRIOR AUTHORIZATION AND APPEALS

Clinical Information

☐ **Please see attached clinical information for the information requested below**

Primary Diagnosis Code: _____ RECENT Platelet Count: Value (K/μL) _____ Date (mm/dd/yyyy) _____

Current therapies patient is taking (to include dose) _____

Other therapies the patient has tried _____ ☐ N/A

Prescriber Information

First Name _____ Last Name _____ ☐ MD ☐ PA ☐ NP

NPI# _____ State License# _____ DEA# _____ Practice Name _____

Street Address _____ City _____ State _____ ZIP _____

If different than above: Office Contact Name _____ Title _____

Phone# _____ Fax# _____ Email Address _____

PRESCRIPTION INFORMATION

This prescription can also be used for the Bridge and Patient Assistance Programs, so please complete even if your pharmacy has another prescription.

By signing below, I, as the treating healthcare practitioner, state: (i) This prescription is medically appropriate for this patient and I will be supervising this patient's treatment; (ii) all information supplied to CTI BioPharma or its agents relating to this support request form is accurate, and has been obtained pursuant to a separate, valid patient authorization that allows CTI BioPharma to contact this patient to provide services relating to (1) treatment and (2) benefit verification and/or preauthorization. I authorize CTI BioPharma or its agents to send the prescription order within this form, on my behalf, to the appropriate specialty pharmacy. Further, I understand that: (a) any free product provided is for the use of this patient only and shall not be sold or transferred to anyone else, or returned for credit; (b) free product may not be counted toward Medicare Part D out-of-pocket costs, nor claimed for reimbursement from any third-party payer (private or government); (c) I am under no obligation to prescribe any CTI BioPharma drug and I have not received and will not receive any benefit from CTI BioPharma for prescribing a CTI BioPharma drug; and (d) CTI BioPharma may revise, change, or terminate programs at any time without notice. I authorize Specialty Pharmacy to initiate any authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans, to the extent not prohibited. See full Prescribing Information at www.VONJO.com for detailed product and dosage information.

Patient Information:

First Name _____ Last Name _____ DOB _____

Known Drug Allergies _____

Prescription: VONJO™ (pacritinib) 100 mg capsules

Sig: _____ Qty: _____ Refills: _____

Prescriber Signature (Dispense as written) (no stamp allowed) _____ Date (mm/dd/yyyy) _____

Prescriber Signature (Substitution permitted) _____ Date (mm/dd/yyyy) _____

If this section does not comply with your state's prescription laws, please provide us with a compliant prescription.

PRESCRIPTION TRIAGE

Pharmacy Information (Preferred pharmacy will be utilized when allowed by the payer.)

☐ Biologics ☐ Onco360 ☐ IOD/MIP/MID/Institution (Please provide name and contact information below.)

Name _____ Phone# _____ Fax# _____

Pharmacy Contact Name _____ Title _____

Phone# _____ Fax# _____ Email Address _____

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