



To Enroll, Fax this form:
 888-385-8482
 Or email: hello@cyclevita.life

ALL REQUIRED FIELDS ARE PURPLE AND NOTED WITH AN ASTERISK*

PATIENT INFORMATION

FIRST NAME*	MIDDLE INITIAL	LAST NAME*	DATE OF BIRTH*	GENDER*
HOME ADDRESS*		CITY*	STATE*	ZIP*
HOME PHONE	MOBILE ☐ OK TO TEXT	WORK	BEST TIME TO CALL	
EMAIL ADDRESS			PREFERRED LANGUAGE IF NOT ENGLISH*	
ALTERNATIVE CONTACT NAME	RELATIONSHIP TO PATIENT		TELEPHONE ☐ OK TO TEXT	

INSURANCE INFORMATION

PLEASE ATTACH A COPY OF THE PRESCRIPTION INSURANCE BENEFIT CARD, FRONT AND BACK, OR COMPLETE THE FOLLOWING*

☐ PRESCRIPTION INSURANCE BENEFIT CARD ATTACHED. ☐ PATIENT DOES NOT HAVE INSURANCE. ☐ PATIENT REQUIRES CO-PAY ONLY.

PRIMARY INSURANCE COMPANY NAME*		SECONDARY INSURANCE COMPANY NAME	
PRIMARY INSURANCE COMPANY PHONE NUMBER*		SECONDARY INSURANCE COMPANY PHONE NUMBER	
NAME OF PRIMARY CARDHOLDER*		NAME OF PRIMARY CARDHOLDER	
PRIMARY INSURANCE MEMBER ID*	GROUP ID*	SECONDARY INSURANCE MEMBER ID	GROUP ID
BIN*	PCN*	BIN	PCN

PRIOR AUTHORIZATION STATUS*

☐ SUBMITTED ☐ NOT SUBMITTED ☐ APPROVED ☐ DENIED

HEALTHCARE PROVIDER (HCP) INFORMATION

HCP FIRST NAME*	HCP MIDDLE INITIAL	HCP LAST NAME*	SPECIALTY
NPI # *		STATE LICENSE #	
OFFICE/CLINIC NAME*	TELEPHONE*	FAX*	GROUP NPI # (IF APPLICABLE)
ADDRESS*		CITY*	STATE* ZIP*
OFFICE CONTACT NAME*	CONTACT TELEPHONE*	CONTACT EMAIL ADDRESS*	
PREFERRED METHOD OF COMMUNICATION: ☐ NO PREFERENCE ☐ OFFICE PHONE ☐ FAX ☐ EMAIL PREFERRED CONTACT TIME: _____			

PATIENT FULL NAME:	DATE OF BIRTH:
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DIAGNOSIS AND PRESCRIPTION (SIGNATURE STAMPS NOT ACCEPTABLE)

☐ **TITRATION DOSE FOR BAFIERTAM**
95MG CAPS (NDC 69387-001-01):

95 mg PO BID x 7 days then increase to 190mg
 (95 mg x 2 capsules) PO BID
 Qty: #120 capsules Refills: No refills

☐ **BRIDGE PROGRAM: †**

"Bridge" is a FREE supply of Bafiertam that allows patients with an urgent medical need to begin therapy immediately while Cycle Vita secures appropriate benefit verification and authorization.

☐ **MAINTENANCE DOSE FOR BAFIERTAM**
95MG CAPS (NDC 69387-001-01):

190 MG (95 MG X 2 CAPSULES) PO BID
 QTY: ☐ 90-day supply #360 capsules Refills: 3
☐ 30-day supply #120 capsules Refills: 11

PRESCRIBER SIGNATURE (dispense as written)*

DATE*

OR

PRESCRIBER SIGNATURE (substitution permitted)

DATE

PRESCRIBER SIGNATURE (dispense as written)*

DATE*

PRESCRIBER SIGNATURE (substitution permitted)

DATE

PLEASE SPECIFY ICD-10 CODE*

- ☐ G35.A: Relapsing-remitting MS
- ☐ G35.C0: Secondary progressive multiple sclerosis, unspecified
- ☐ G35.C1: Active secondary progressive multiple sclerosis
- ☐ G35.D: Multiple sclerosis, unspecified
- ☐ G36.8: Other specified acute disseminated demyelination
- ☐ G36.9: Acute disseminated demyelination, unspecified
- ☐ G37.8: Other specified demyelinating diseases of the central nervous system
- ☐ G37.9: Demyelinating disease of the central nervous system, unspecified
- ☐ Other (please specify): _____

CURRENT/MOST RECENT MS THERAPY*

☐ NO PRIOR MS THERAPY

MEDICATION: _____ DATES OF THERAPY: _____

MEDICATION: _____ DATES OF THERAPY: _____

†By checking the box above for Bridge, I, as the prescriber, with my signature below on this form, agree and attest that I will not submit a claim to or seek payment from the patient or any third-party payer (e.g., Medicaid, Medicare, private insurance, etc.) for payment/reimbursement for any free product(s) provided by Cycle Vita[™]. I agree and understand that any free product provided by Cycle Vita may not be sold, traded, bartered, transferred, or returned for credit and will only be used for the patient named above on this form. Cycle Vita reserves the right to modify or terminate the program without notice at any time.

Bridge is at no cost, for eligible patients within labeled indication only, and not contingent on purchase of any kind. Bridge is intended to support continuation of prescribed therapy if there is any disruption in therapy due to insurance coverage.

PHYSICIAN SIGNATURE REQUIRED FOR AUTHORIZATION

I authorize Banner Life Sciences LLC, and its affiliates, agents and service providers ("Banner") as my designated agent and on behalf of my patient to provide any information on this form to the insurer, forward the above prescription by any means as allowed by applicable law to a pharmacy that can provide the prescribed medication and otherwise provide any information on this form for use as authorized by the above named patient. If my patient has not signed the Patient Authorization section of this form, I certify that I have my patient's authorization, including under HIPAA and other applicable privacy laws, for the release of my patient's identification and insurance information to Banner for benefits verification and coordination of benefits. By signing, prescriber certifies that the above is medically necessary.

HCP Prescriber Signature:*

Date:*