BOEHRINGER INGELHEIM REFERRAL FORM

Please complete and fax this form to 1-866-867-1861
Contact BI Solutions Plus: 1-844-8-SOLUTION (1-844-876-5884), Monday – Friday, 8:00 am – 8:00 pm, ET.

Solutions Plus™ Patient support. Our priority.™

Boehringer Ingelheim

PATIENT INFORMATION

NAME (First, MI, Last): _____
ADDRESS: _____
CITY: _____
STATE: _____ ZIP CODE: _____
E-MAIL: _____
HOME PHONE: _____
WORK PHONE: _____ CELL PHONE: _____
SEX ❑ M ❑ F DOB (MM/DD/YYYY): _____
ALLERGIES: _____

INSURANCE INFORMATION (Complete this section or provide a copy of insurance card)

PRIMARY INSURANCE

POLICY HOLDER NAME _____
RELATIONSHIP TO CARDHOLDER _____ POLICY HOLDER DOB _____
PAYER/PLAN NAME _____
PAYER/PLAN PHONE# _____
POLICY# _____ GROUP# _____

SECONDARY INSURANCE

POLICY HOLDER NAME _____
RELATIONSHIP TO CARDHOLDER _____ POLICY HOLDER DOB _____
PAYER/PLAN NAME _____
PAYER/PLAN PHONE# _____
POLICY# _____ GROUP# _____
PBM NAME _____
PBM PHONE# _____
CARD/BIN# (Please include alpha prefix/suffix with policy, group and/or PCN #'s when applicable) _____

PRESCRIBER INFORMATION (Verification of Benefits will be faxed to this Prescriber)

PRACTICE NAME: _____ OFFICE CONTACT: _____
PRESCRIBER'S NAME (FIRST, LAST): _____ SPECIALTY: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP CODE: _____
E-MAIL: _____
PHONE: _____ FAX: _____
MEDICAID/MEDICARE PROVIDER# _____ TAX ID# _____
STATE LICENSE# _____ UPIN/NPI# _____

BENEFIT INVESTIGATION FOR:

DIAGNOSIS FOR WHICH THIS MEDICATION IS BEING PROCESSED: _____

❑ STIOLTO RESPIMAT ❑ SPIRIVA HANDIHALER
❑ SPIRIVA RESPIMAT 1.25 mcg/actuation ❑ COMBIVENT RESPIMAT
❑ SPIRIVA RESPIMAT 2.5 mcg/actuation

DATE OF DIAGNOSIS: _____ ❑ Male ❑ Female ICD-10: _____
DRUG PRESCRIPTION: _____ MEDICATION NAME: _____
❑ NEW TO MEDICATION ❑ RESTART ❑ CONTINUING (START DATE) _____
QUANTITY: _____ REFILLS: _____

BENEFIT INVESTIGATION FOR:

DIAGNOSIS FOR WHICH THIS MEDICATION IS BEING PROCESSED: _____

❑ PRADAXA 75 mg ❑ PRADAXA 110 mg ❑ PRADAXA 150 mg
DATE OF DIAGNOSIS: _____ ❑ Male ❑ Female ICD-10: _____
DRUG PRESCRIPTION: _____ MEDICATION NAME: _____
❑ NEW TO MEDICATION ❑ RESTART ❑ CONTINUING (START DATE) _____
QUANTITY: _____ REFILLS: _____

Prior Authorization

If you would like Solutions Plus by Boehringer Ingelheim to provide support for the prior authorization process, please check the applicable box(es) below:

☐ **Prior Authorization Form Assistance** By checking this box, I request that Solutions Plus by Boehringer Ingelheim assist my office in determining the requirements of this patient's health plan relating to prior authorization for the medication(s) specified above. I understand that such assistance includes procurement of the health plan-specific prior authorization form, and completion of the insurance and patient and provider demographic information sections thereon based on information provided by my office on this referral form. I understand that any partially completed prior authorization forms will be provided by Solutions Plus by Boehringer Ingelheim and that completion and submission of the form to the above named patient's health plan is the responsibility and in the discretion of my office.

☐ **Prior Authorization Monitoring Status** I hereby request and authorize Solutions Plus by Boehringer Ingelheim to monitor status of the prior authorization submissions for the above named patient and to provide status updates to my office with respect to this patient's prior authorization for treatment with the specified medication(s).

FOR STATES REQUIRING HANDWRITTEN EXPRESSIONS FOR PRODUCT SELECTION, USE THIS AREA (e.g., medically necessary, may not substitute, dispense as written, etc.)

LEGAL INFORMATION

Physician Certification

I verify that the patient and physician information contained in this enrollment form is complete and accurate to the best of my knowledge and that I have prescribed the products identified on this form based on my professional judgment of medical necessity. I authorize Boehringer Ingelheim Pharmaceuticals, Inc. ("Boehringer Ingelheim"), its affiliated companies, vendors, agents, and representatives (collectively, "Solutions Plus by Boehringer Ingelheim") to perform a preliminary assessment of insurance verification for the above-named patient. If my patient is eligible to receive free product under Boehringer Ingelheim's Patient Assistance Program (PAP), I certify and agree that neither I nor anyone on my behalf shall submit a claim to any third-party payer for payment of product provided under that program. I warrant that any product provided to me under the Boehringer Ingelheim PAP will be provided only to the approved patient and will not be sold, traded, or returned for credit.

I further confirm that I understand that insurance verification and other information provided by Solutions Plus by Boehringer Ingelheim in any patient access support program are provided as a service to patients and that Solutions Plus by Boehringer Ingelheim makes no representation or guarantee that any insurance reimbursement or other payment for the BI Products I prescribe will be available. I also understand Solutions Plus by Boehringer Ingelheim makes no representations or warranties, expressed or implied, about the accuracy of the information and that Solutions Plus by Boehringer Ingelheim is not liable for any damages resulting from or relating to the Solutions Plus program services.

Prescriber Signature: *(Required to validate prescriptions)*

_____ _____

Dispense as written / Do not substitute Date Substitution permitted / Brand exchange permitted Date

The undersigned further certifies that I have obtained all necessary authorizations and approvals, if any, required by law or regulation to have been obtained from the above named patient to permit the sharing of Health Information with Solutions Plus by Boehringer Ingelheim. I also confirm that I will if required by law or regulation execute a Business Associate Agreement ("BAA") with Boehringer Ingelheim's vendor for patient access support services. A form BAA has been provided to me.

Prescriber Signature:

_____

Patient Representative Signature Date

Please see accompanying full Prescribing Information and Instructions for Use for Spiriva® Respimat® (tiotropium bromide) Inhalation Spray, Combivent® Respimat® (ipratropium bromide & albuterol).

Please see accompanying full Prescribing Information for Stiolto™ Respimat® (tiotropium bromide and olodaterol) Inhalation Spray, including Boxed Warning, Medication Guide, and Instructions for Use.

Please see accompanying full Prescribing Information for Pradaxa® (dabigatran etexilate mesylate) Capsules including Boxed Warning.