vevye™ (cyclosporine ophthalmic solution) 0.1%

Prescription Fax Order Form

Fax this completed prescription form to PhilRx at 888.975.0603

Patient Information

Name: _____ Date of Birth *(MM/DD/YYYY):* _____

Cell Phone: (___)_____ Email: _____

Shipping Address: _____ City: _____ State: _____ ZIP: _____

Sex: Male ☐ Female ☐ Primary Language: _____

Prescriber Information

Name: _____ NPI #: _____

Address: _____ City: _____ State: _____ ZIP: _____

Office Contact Name: _____

Phone:(___)_____ Fax: (___)_____ *(for prescription status updates)*

Strength/Form	Quantity	How Supplied	Day Supply	Refills	Dosage/Administration
VEVYE® (cyclosporine ophthalmic solution) 0.1%		One 2mL bottle/ One box	30		One drop, each eye, twice daily (approximately 12 hours apart)

ICD-10 or Diagnosis: _____

Prior Medication Trials/Failures *(treatment name, duration, and reason for discontinuation):*

_____

Insurance Information

(Please attach a copy of the front and back of the patient's insurance card **OR** *fill out the information below)*

Check the box that applies:

Commercial/Private ☐ Medicare Part D ☐ Medicaid ☐ Other ☐ Uninsured ☐

Member Name *(cardholder):* _____ Rx Plan Name: _____

Prescription Drug Card Member ID *#:* _____ Rx Group: _____

Rx BIN: _____ Rx PCN: _____

Prescriber Signature: _____ Date: _____

Transmitted by *(full name if other prescriber):* _____

Have questions or need assistance?

Call **855-977-0975** and press **option 2** to speak with a PhilRx Support Representative or contact your VEVYE Sales Reprentative.

HARROW™
Your patients. Our purpose.