Patient Benefit Investigation Form

Phone (855) 336-3322
Fax (800) 481-3325

CORE CONNECTIONS
Coverage, Resources and Education

Patient ID: _____
(Internal Use Only)

Patient Information (Required)*

***First Name:** _____ MI: _____ ***Last Name:** _____ ***Sex:** ❑M ❑F

Email: _____ Last 4 SSN: _____ ***DOB:** _____

***Mobile Phone:** _____ Alt. Phone: _____ Preferred : ❑Mobile ❑ Alt. Phone ❑ Text ❑ Email

***Address:** _____ ***City:** _____ ***State:** _____ ***Zip:** _____

***Allergies:** _____ ***Other Medications:** _____

❑ **M06.9 Rheumatoid arthritis, unspecified** ❑ **M 08.00 Unspecified JRA** ❑ **L40.9 Psoriasis, unspecified**

Other Diagnosis Code: _____ ❑**Medication List Attached** **Prior Oral Methotrexate?**: _____

Insurance Information

***Does patient have insurance:** ❑Yes ❑No

***Health Plan Insurer:** _____

***Insurer Member ID #:** _____

Insurer Plan Phone #: _____

Cardholder Name: _____

***Patient's Pharmacy of Choice:** _____

Rx Benefit Plan: _____

Rx Member ID #: _____

Rx Plan Phone #: _____

Relationship to Cardholder: ❑Self ❑Spouse ❑Other

Prescriber Information

***Physician Name:** _____ ***NPI #:** _____ ***State License #:** _____

Practice Name: _____

***Office Phone:** _____ Alt.Phone: _____ Fax: _____ Email: _____

Preferred Communication: ❑Office ❑ Alt. Phone ❑ Fax ❑ Email Best Time to Contact: ❑ Morning ❑ Afternoon ❑ Evening

***Address:** _____

***City:** _____ ***State:** _____ ***Zip:** _____

Office Contact Name: _____ Contact Phone: _____

Drug Information

Medication	Strength	Directions	Quantity
Rasuvo (Methotrexate Inj. SC)	❑7.5mg ❑10 mg ❑12.5mg ❑15 mg ❑17.5 mg ❑20 mg ❑22.5 mg ❑25 mg ❑30 mg	Inject every week as directed	_____ Qty

I authorize my healthcare provider, my health insurance company, and my pharmacy providers ("Healthcare Entities") to disclose to Medexus Pharma and companies working with Medexus Pharma, which may be branded as CORE Connections™ (collectively, "Medexus Pharma"), my contact information, health information relating to my medical condition to the extent necessary to support treatment that may also include identifying any potential drug interactions evaluation and allergies, and insurance coverage for Medexus Pharma to (i) provide me with support services (which may be branded as CORE Connections™) and related information and materials on any of Medexus Pharma products, including, but not limited to, educational support provided in-person, online or by telephone, financial assistance services, medication adherence services, (ii) conduct data analytics, market research and other internal business activities including, but not limited to, evaluating the services provided, and (iii) provide me with information about Medexus Pharma products, services, and programs and other topics of interest for marketing, educational or other purposes. Once my health information has been disclosed to Medexus Pharma, I understand that Federal privacy laws no longer protect the information and that the information may be subject to further disclosure by Medexus Pharma. However, Medexus Pharma agrees to protect my health information by using and disclosing it only for purposes authorized in this Patient Authorization and Consent or as required by law or regulations. I understand that my pharmacy provider may receive remuneration from Medexus Pharma in exchange for sharing information concerning any services that the pharmacy may provide to me. I understand that I may refuse to sign this Authorization, and I further understand that my treatment (including with a Medexus Pharma product), payment for treatment, insurance enrollment or eligibility for insurance benefits are not conditioned upon my agreement to sign this Authorization. However, if I do not sign this Authorization, or later cancel it, I will not be able to receive any support services from Medexus Pharma including those branded as CORE Connections. I may cancel this Authorization at any time by mailing a letter to: Medexus Pharma. Canceling this Authorization will end my consent to further disclose health information to Medexus Pharma by my Healthcare Entities after they are notified of my cancellation, but will not affect previous disclosures by them pursuant to this Authorization. Canceling this authorization will not affect my ability to receive treatment, payment for treatment, or my eligibility for health insurance. This Authorization expires December 31, 2028 or such shorter time-frame required by applicable law, from the day I sign it as indicated by the date next to my signature unless otherwise canceled earlier as set forth above. I have read, understand, and agree to the terms in section I above, Authorization to Share Health Information.

Patient Signature: SIGN HERE _____ **Date:** ENTER DATE HERE _____