ORBACTIV® Support Programs
PO Box 4280
Gaithersburg, MD 20855-4280

ORBACTIV® (oritavancin) Support Programs

HEALTHCARE PROVIDER REQUEST FORM

Phone: 1-844-ORBACTIV (1-844-672-2284) **Fax:** 1-855-886-2482
Hours: Monday through Friday, 8am – 8pm ET

SERVICE (S) REQUESTED

Check all that apply:
- ☐ **Insurance Verification**
  - ☐ **Check here to also include KIMYRSA insurance verification**
- ☐ **Copay Savings Program**
- ☐ **Prior Authorization Assistance**
- ☐ **Claims Assistance**
- ☐ **Patient Assistance Program (PAP)**

(NOTE: For Copay Savings Program and Patient Assistance Program, complete and sign page 2)

APPLICATION CHECKLIST (Research may be delayed if all information is not received)

Confirm all are completed:
- ☐ **Prescriber, Facility & Shipment**
- ☐ **Patient**
- ☐ **Diagnosis and Treatment**
- ☐ **Applicable Signatures**

AUTHORIZING HEALTHCARE PROVIDER, FACILITY & SHIPMENT INFORMATION (Stock replacement for Patient Assistance Program requests will be shipped to the address listed)

Physician Name:		Specialty:	
Physician Tax ID#		Physician NPI#	
State License# (Provide copy of license if available)	Issuing State	Expiration Date of license (if available)	
Facility Name		Facility Contact Name	
Facility Address	City	State	Zip Code
Contact Name	Contact Phone#	Contact Email	
Fax#	Facility Tax ID#	Facility NPI#	

Preferred Method of Contact

What is your preferred method to receive program communication**?** ☐ Fax ☐ Email (If checked, please provide email address:_____)
****Please note:** All communication is sent via fax if this is not checked**

PATIENT INFORMATION (required)

Patient Name	Date of Birth	SSN/ID# (last 4 digits)	
Phone#	US Resident? ◯ Yes ◯ No	Gender ◯ M ◯ F	
Patient Address	City	State	Zip Code

PATIENT INSURANCE INFORMATION (Attach a copy of both the front and back of insurance cards, if available). **CHECK HERE IF UNINSURED** ☐

Primary Insurance	Insurer Phone#	Policy#	Group#
Policy Holder's Name	Policy Holder's Date of Birth		
Secondary Insurance	Insurer Phone#	Policy#	Group#
Policy Holder's Name	Policy Holder's Date of Birth		

DIAGNOSIS and TREATMENT INFORMATION (required)

SETTING of CARE: ☐ Hospital Inpatient ☐ Hospital Outpatient ☐ Physician's Office ☐ Home Infusion ☐ Other – Please specify

Date of Service: **ICD-10 Code:** **HCPCS Code:**

AUTHORIZING HEALTHCARE PROVIDERCERTIFICATION AND CONSENT (required)

I certify to the best of my knowledge that the information above is accurate and complete. I have requested and received consent from the patient or the patient's guardian to enroll the patient in the designated ORBACTIV® Support Programs and I agree to allow the ORBACTIV® Support Programs, or its authorized representative, to review the medical, financial and insurance records for this patient at any time for the purpose of verifying the patient's eligibility status. I also attest that I have secured the patient's or the patient's guardian's written permission, to the extent and in the form required by law, to disclose the information to the ORBACTIV® Support Program's authorized representative. If Patient Assistance Program (PAP) services are requested, I represent that this patient has no medical or prescription insurance coverage for the applied for drug, including all public programs; my signature further certifies that no claims for payment for product provided under the PAP will be made to any private, federal or state healthcare program, or to the patient. I further agree that the ORBACTIV® Support Programs may contact me and my office via telephone, fax and e-mail regarding this enrollment request and related follow-up, and that I can revoke my consent at any time.

Authorizing Healthcare Provider:
I have read and agree to the terms detailed on this form.

X_____ **Sign Here** _____
Authorizing Healthcare Provider's original signature (no stamped signatures) Date

To opt-out of receiving future faxes, please contact us at 1-844-ORBACTIV (1-844-672-2284) (phone) or 1-855-886-2482 (fax).

ORBACTIV® (oritavancin) Support Programs

PHYSICIAN REQUEST FORM

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PATIENT INFORMATION

Patient Name: Date of Birth:

COMPLETE THIS SECTION ONLY IF APPLYING FOR THE PATIENT ASSISTANCE PROGRAM

Patient's total Annual Household Income* $ Household Size (including patient)

PATIENT, AUTHORIZED CAREGIVER, or AUTHORIZING HEALTHCARE PROVIDERATTESTATION and AUTHORIZATION (Required)
I attest that the information supplied above is complete and accurate, to the best of my knowledge. The patient is not enrolled in any government funded healthcare program, including but not limited to Medicare, Medicaid, including managed Medicaid, or Tricare.. I acknowledge, or, if not the patient, I acknowledge on the patient's behalf, that Melinta Therapeutics may discontinue this program or change its eligibility criteria at any time and without notice, and that the ORBACTIV® Support Programs may contact me vial mail, telephone, fax and e-mail regarding this enrollment request and related follow-up, and that I can revoke my consent at any time.

Print Name: Indicate Relationship to Patient: ☐ Patient (self) ☐ Authorized Caregiver ☐ Prescribing Clinician

Signature: Sign Here Date:

PATIENT ASSISTANCE PROGRAM DISCLAIMER: MELINTA THERAPEUTICS reserves the right to request additional documentation to confirm eligibility.

COPAY SAVINGS PROGRAM PAYMENT INFORMATION

Payment will be in the form of a Virtual Debit Card (VDC) via email –Email address is Required:_____

COPAY SAVINGS PROGRAM DISCLAIMER

Patients must be United States residents and be 18 years of age or older. Eligible patients must have a minimum of a $50 copayment, coinsurance or deductible obligation for ORBACTIV® (oritavancin) for Injection. The Program will cover up to $500 of a patient's obligation, and the patient must contribute $50 toward their copay/coinsurance. Patients who pay cash or who are enrolled in or participate in any type of government insurance or reimbursement programs, including but not limited to Medicare, Medicaid, including managed Medicaid, and Tricare are not eligible. As a condition precedent of the copayment or coinsurance support provided under this program, e.g., copay or coinsurance amounts paid to administering providers, participating patients and administering providers are obligated to inform insurance companies and third-party payors of any benefits they receive and the value of this program, as required by contract or otherwise. Void where prohibited by law, taxed, or restricted. Additional terms and conditions may apply. Patients enrolled in the ORBACTIV® Patient Assistance Program are not eligible. Melinta Therapeutics may determine eligibility, monitor participation, and modify or discontinue any aspect of this Program at any time. For additional information regarding ORBACTIV®, including Important Safety Information, please see the Full Prescribing Information available at www.orbactiv.com.

Thank you for contacting the ORBACTIV Support Program. We are here to help you and your patients.
Please contact us at 1-844-ORBACTIV (1-844-672-2284), fax 1-855-886-2482,
or send written communication to PO Box 4280, Gaithersburg, MD 20855-4280

This verification of benefits is not a guarantee of payment. This verification cannot take the place of written policy information from the payer. For additional assistance please contact the ORBACTIV Support Program at 1-844-ORBACTIV.

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To opt-out of receiving future faxes, please contact us at 1-844-ORBACTIV (1-844-672-2284) (phone) or 1-855-886-2482 (fax).

