ACHAOGEN

Service Request Form

Call toll-free: 833-252-6266
Monday - Friday: 8:00 AM to 5:00 PM, ET
Fax to: 833-252-6925

***Complete all required fields to avoid delay in processing.**

Patient Information

*Patient Name:

* ☐ Male ☐ Female | *DOB: / /

*Address:

*City/State/Zip:

*Home Phone: *Cell Phone:

Preferred Phone: ☐ Home ☐ Cell

Email:

Language: ☐ English ☐ Spanish ☐ Other

Best Time to Contact: ☐ Morning ☐ Afternoon ☐ Evening

Insurance Information

Please include copy of front and back of patient's insurance card(s)

*Primary Insurance: *Policy ID#:

Group #: Phone #:

Subscriber's Name: (if not self) Employer:

Secondary Insurance: Policy ID#:

Group #: Phone #:

Subscriber's Name: (if not self) Employer:

Prescriber Information

*Prescriber Name: MD Specialty:

Practice Name: Office Contact:

*NPI #: State Med Lic #:

Tax ID #: PTAN:

*Address:

*City/State/Zip:

Phone: Fax:

Email:

Program Options

*Select One:

Benefit Investigation:	☐ Plazomicin 15 mg/kg	☐ Site of Administration
Prior Authorization Support:	☐ Plazomicin 15 mg/kg	☐ Site of Administration
Appeal Support:	☐ Plazomicin 15 mg/kg	☐ Site of Administration

Site of Administration

*Select One:
☐ Outpatient Hospital
☐ Specialty Infusion Center
☐ Home Infusion
☐ Other: _____

*Name of Site/Agency:

*Phone: Fax:

*Address:

*City/State/Zip:

*NPI #: Tax ID:

Contact Name: Phone:

Diagnosis and Clinical Information

*Diagnosis (Please indicate *ICD-10* Code):

Currently taking plazomicin ☐ Yes ☐ No Start Date: / /

Directions:

Plazomicin injection for IV Infusion
Infuse ____ mg every day for _____ days over _____ minutes.

Dispense Quantity: ____ vials, 500 mg in 10 mL (50 mg/mL) NDC 71045-010-01

Prescriber's Signature

By signing below, I certify that (a) the above-prescribed therapy is medically necessary and, (b) I have received from the patient identified above, or his/her personal representative, the necessary authorization to release, in accordance with applicable federal and state privacy laws and regulations, referenced medical and/or other patient information relating to the need for the above-prescribed therapy(ies), to Achaogen, Inc. and its agents or contractors for the purpose of seeking information related to coverage for the therapy(ies) and/or assisting in initiating or continuing therapy.

▶ ***Prescriber's Signature:
NO STAMPS PLEASE Date: