

Patient Benefit Investigation Form

Phone (855) 33MEDAC (855) 336-3322

Fax (800) 481-3325



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 Communication: 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 *Patient's Pharmacy of Choice: _____
 *Health Plan Insurer: _____ Rx Benefit Plan: _____
 *Insurer Member ID #: _____ Rx Member ID #: _____
 Insurer Plan Phone #: _____ Rx Plan Phone #: _____
 Cardholder Name: _____ Relationship to Cardholder: Self Spouse Other

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

Practice Name: _____

*Office Phone: _____ Alternate 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)	<input type="checkbox"/> 7.5mg <input type="checkbox"/> 10 mg <input type="checkbox"/> 12.5mg <input type="checkbox"/> 15 mg <input type="checkbox"/> 17.5 mg <input type="checkbox"/> 20 mg <input type="checkbox"/> 22.5 mg <input type="checkbox"/> 25 mg <input type="checkbox"/> 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 Medac Pharma and companies working with Medac Pharma, which may be branded as CORE Connections™ (collectively, "Medac 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 Medac Pharma to (i) provide me with support services (which may be branded as CORE Connections™) and related information and materials on any of Medac 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 Medac Pharma products, services, and programs and other topics of interest for marketing, educational or other purposes. Once my health information has been disclosed to Medac Pharma, I understand that Federal privacy laws no longer protect the information and that the information may be subject to further disclosure by Medac Pharma. However, Medac 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 Medac 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 Medac 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 Medac Pharma including those branded as CORE Connections™. I may cancel this Authorization at any time by mailing a letter to: Medac Pharma. Canceling this Authorization will end my consent to further disclose health information to Medac 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: _____ Date: _____

