gammaCore

Patient Enrollment Form

Customer Service: (844) 632-9264
Fax completed form to: (877) 427-4186
Email completed form to: gammaCAREdirect@asembia.com

☐ Check here if your patient is enrolled in gammaCore Patient Registry

***Indicates required field**

PRESCRIPTION INFORMATION

*Patient Name (Last, First):

*Date of Birth: Gender: M ☐ F ☐

*Address: (Cannot be a PO Box)

*City *State *Zip

*Cell *Home Phone

*Email *SSN

Emergency contact: Phone #:

Device: **gammaCore**

*Date *Days Supply: **31**

*Quantity: **1** *Refills:

***Sig (Directions):** gammaCore® (non-invasive vagus nerve stimulator) is indicated for the acute treatment of pain associated with episodic cluster headache and migraine in adult patients. Please refer to the gammaCore Instructions for Use for all of the important warnings and precautions before using or prescribing this product.

PROVIDER ATTESTATION

By signing below, I verify that the information being disclosed in this enrollment form is complete and accurate to the best of my knowledge. I understand that ASPN Pharmacies, LLC (ASPN) reserves the right at any time and for any reason, without notice, to modify this enrollment form or to modify or discontinue any services or assistance provided through this Program. Finally, I authorize ASPN as my designated agent to use and disclose my patient's protected health information as may be necessary for treatment, payment, and healthcare operations, including to verify the accuracy of any information provided, to verify patient eligibility, to provide for payment and reimbursement, and to forward the above prescription information, by fax or other mode of delivery, to a pharmacy for fulfillment. Finally, I allow ASPN to email me regarding prescription status updates and act as my prior authorization agent in dealing with prescription and medical insurance companies.

*Prescriber's Signature

Signature is required to process the prescription. Stamped signatures are not permissible.

(Dispense As Written)

*Date of Signature

PRIMARY PRESCRIPTION INSURANCE

(1) Fill in fields with pharmacy insurance information (NOT medical), OR (2) Fax Patient Demographic Information or Patient Insurance Card along with enrollment form.

*Insurance Name: Pharmacy Help Desk Phone #:

Policyholder Name: *Relationship to Patient:

*Member ID: *Group ID:

*Rx BIN: *PCN:

MEDICAL INSURANCE INFORMATION

*Primary Insurance: *Phone:

*Member ID: *Group ID:

Secondary Insurance: Phone:

Member ID: Group ID:

PRESCRIBER INFORMATION

*Prescriber Name (Last, First):

*NPI:

*Prescriber's Primary Specialty: ☐ **Neurology** ☐ **Other**_____

*Prescriber Phone: *Fax:

*Address:

*City: *State: *Zip:

Email:

*Tax ID: *DEA:

Prescriber Office Contact Information

*Office Contact Name (Last, First):

*Email: *Phone:

CLINICAL INFORMATION

*Diagnosis: ☐ G43.___ - Migraine
☐ G44.011 - Episodic cluster headache, intractable
☐ G44.019 - Episodic cluster headache, not intractable
☐ Other_____

History of, or at risk for, severe allergic reaction to:

electroCore®

gammaCore®

Patient Authorization

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By signing this document (this "Authorization"), I authorize my doctor(s) and their staff, my health insurer(s), and the specialty pharmacy or distributor that will supply gammaCore® ("gammaCore") and/or fill my prescription (the "Pharmacy") to disclose my personal information, including but not limited to, patient ID, device ID, and related information ("ID Information") to electroCore, its business partners and agents, including Asembia LLC ("Asembia"). I understand that my ID Information will be used by electroCore, its business partners and agents to (i) permit electroCore to oversee administration of treatment and conduct market analyses or ways to improve access to gammaCore, including aggregating my ID Information with other data aimed at improving the care provided to me and others receiving the treatment; and (ii) assist with analyses related to quality, efficacy, and safety for gammaCore. Asembia may receive indirect or direct remuneration in connection with the use or disclosure of your information for marketing purposes.

I understand that once my ID Information is disclosed, it may no longer be protected by federal or state laws regarding patient privacy and it may be subject to re-disclosure without my permission. ElectroCore, its business partners and agents agree to use and disclose my ID Information only for the purposes described in this Authorization or as required by law.

I understand that I may refuse to sign this Authorization, or revoke it at any time in the future, and that my refusal or future revocation will not affect my treatment, payment, or eligibility for benefits but may affect my ability to receive gammaCore. Revoking this Authorization will not affect the ability of electroCore, its business partners and agents to use and disclose ID Information it received while this Authorization was in effect. I may revoke my Authorization at any time by written notice to:

Asembia LLC
200 Park Ave, Suite 300
Florham Park, NJ 07932

or by calling 1-888-903-CORE (2673) and following the instructions provided. I also understand that the Program may be changed or ended at any time with prior notification and that I will receive a copy of this Authorization. This Authorization shall terminate upon conclusion of the Program or earlier if required by applicable law. I understand that I will receive a copy of this signed authorization.

Patient Signature | Print Name | Date

electroCore®
The NeuroScience Company™