Pertzye® Care Program

Co-Pay Assistance $0 out of pocket co-pay expense

Freedom Pharmacy accepts E-scribe.
Freedom Pharmacy
3901 E. Colonial Dr., Orlando, FL 32803

Pertzye®
(pancrelipase)
Delayed-Release Capsules
Containing Bicarbonate-Buffered Enteric-Coated Microspheres

Digestive Care, Inc. gives you two options to start your patients on Pertzye®

OPTION 1: Sample of 80 capsules sent directly to your patient.

OPTION 2: A prescription of Pertzye® at $0 out-of-pocket co-pay expense, including deductibles for eligible patients.*

Please **FILL OUT** the form on the reverse side.

FAX completed form to Freedom Pharmacy at 866-482-6158.

or

E-SCRIBE to Freedom Pharmacy 3901 E. Colonial Dr., Orlando, FL 32803

***Eligibility:** Available to patients with commercial prescription insurance coverage for Pertzye®. Co-pay and deductible assistance is not available to patients receiving reimbursement under any federal, state, or government-funded insurance programs (for example, Medicare, Medicaid, TRICARE, Department of Defense, or Veterans Affairs programs) or where prohibited by law. Offer subject to change or discontinuance without notice. **This is not health insurance.**

DCI Digestive Care, Inc.
1120 Win Drive, Bethlehem, PA 18017-7059
Voice: 1-877-882-5950 | **Fax:** 610-882-0349 | **www.pertzye.com**

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Pertzye® (pancrelipase) Delayed-Release Capsules

Containing Bicarbonate-Buffered Enteric-Coated Microspheres

Date: _ _ - _ _ - _ _ _ _
Month Day Year

Pertzye® Care Program

Please check ☑ one option:

☐ **OPTION 1** Sample of 80 capsules sent directly to your patient.

Select dosage ☐ **Pertzye® 4,000** ☐ **Pertzye® 8,000** ☐ **Pertzye® 16,000** ☐ **Pertzye® 24,000**

☐ **OPTION 2** A prescription of Pertzye® at $0 out-of-pocket co-pay expense, including deductibles for eligible patients.* (See Sig: below)

Qty. of capsules

Select dosage ☐ **Pertzye® 4,000** ☐ **Pertzye® 8,000** ☐ **Pertzye® 16,000** ☐ **Pertzye® 24,000**

Sig:

Physician Signature:_____ **Number of Refills:**_____

Physician Information:

Physician Name: Specialty:

DEA #

Clinic Name: Phone:

Clinic Address: Fax:

City: State: Zip:

Patient Information:

Patient Name: Phone: Date of Birth:

Patient Street Address: (do not use P.O. Box Number)

City: State: Zip:

Allergies: Diagnosis:

Patient Insurance Information for **PRESCRIPTION**

(For your convenience, a Freedom Pharmacy Customer Service Representative can contact patient to collect insurance information.)

Insurance Plan Name:

ID #: Group #:

RX Bin #: RX PCN #:

Insurance Plan Phone:

Name of Person Insured:

Fax this Pertzye® Care Program form to Freedom Pharmacy at: **Fax 866-482-6158 or send via E-scribe**

DCI Digestive Care, Inc.
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Freedom Pharmacy & Wellness Center

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