Velsipityforme
PATIENT SUPPORT PROGRAM

VELSIPITY® (etrasimod)

Baseline Assessment Confirmation

Tier 1 Review.
This will replace PP-V1A-USA-0782 to include reminder within the instructions

Instructions for Prescriber

This form is used by the VelsipityForMe patient support program to confirm:

- Baseline assessments for the patient have been completed and reviewed by their prescriber
- The patient is able to begin VELSIPITY® (etrasimod) treatment

Please complete the following steps:

1. Read and sign the form with the prescriber's signature.
2. Fax completed form to 1-646-862-9655.

REMINDER: DO NOT ATTACH ANY CLINICAL OR OFFICE NOTES AS THIS MAY DELAY PROCESSING.

PATIENT INFORMATION

**Required Field*

First Name* _____ Middle Initial ____ Last Name* _____

Date of Birth (mm/dd/yyyy)* _____

PRESCRIBER INFORMATION

Full Name* _____ Prescriber NPI* _____ Site Phone* _____

Site Name and Address* _____

City* _____ State* _____ ZIP* _____

Healthcare Provider Authorization

By signing, I verify, based on my review of the baseline tests, the patient identified above has completed the baseline assessments required for VELSIPITY treatment and in my independent medical judgment is appropriate for treatment with VELSIPITY. Accordingly, I provide authorization for this patient to proceed with initiation of therapy with VELSIPITY.

Signature* (NO STAMPS ALLOWED)* _____

Date* (mm/dd/yyyy)* _____

FAX completed form to 1-646-862-9655

CALL with questions 1-800-350-3080