Velsipityforme
PATIENT SUPPORT PROGRAM

VELSIPITY® (etrasimod)

Pre-Initiation Assessment Confirmation

Instructions for Prescriber

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

- Required pre-initiation assessments (ECG, blood tests) for the patient have been completed and reviewed by the provider
- 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 that the patient identified above has completed the pre-initiation assessments required to start 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