

# ENDO Reimbursement Services Hotline Service Request Enrollment Form

**VALSTAR® (valrubicin)**  
Phone - 1-800-462-ENDO (3636)  
Fax - 1-800-847-9804

**TREATMENT INFORMATION** (please provide a copy of all supporting documentation related to treatment along with this form)

<input type="checkbox"/> Immediate Cystectomy would be associated with unacceptable morbidity and mortality		
Primary ICD-9-CM diagnosis (specify): <input type="checkbox"/> 233.7 Carcinoma <i>in situ</i> of Bladder <input type="checkbox"/> Other <small>* The sample diagnosis code is for informational and is not intended to be directional.</small>	Secondary ICD-9-CM diagnoses (specify):	Other: (List only codes relevant to VALSTAR® procedure.)
New Therapy Start Yes <input type="checkbox"/> No <input type="checkbox"/> If yes: Scheduled Date of Service:	Continued Therapy: Yes <input type="checkbox"/> No <input type="checkbox"/> If yes: Date of last treatment:	Place of service: Physician Office <input type="checkbox"/> Hospital Outpatient <input type="checkbox"/> Other <input type="checkbox"/> (specify):
Additional information:(specify)		

**PATIENT INFORMATION** (please attach an enlarged copy of the front and back of the patient's insurance card and /or other insurance information along with this form)

Patient Name (First):	Last:	MI:	Date of Birth:
Patient Address:		City:	State: Zip:
Patient Social Security #:	Daytime Phone #:	Cell/Work Phone #:	Evening Phone #:
Primary Insurance Name:	Phone #:	Subscriber ID #:	Group ID #:
Subscriber Name and Date of Birth (mm/dd/yr):		Subscriber Social Security #:	Employer Name:
Prescription Insurance Name:	Phone #:	Subscriber ID #:	Group ID #:
Secondary Insurance Name:	Phone #:	Subscriber ID #:	Group ID #:
Subscriber Name and Date of Birth (mm/dd/yr):		Subscriber Social Security #	Employer Name:

**PRESCRIPTION INFORMATION:**

Product Name: <b>VALSTAR® (valrubicin) 200mg/5mL sterile solution for intravesical instillation</b>	
NDC #: <b>67979-001-01 (Carton of 4 vials)</b>	J-code: <b>J9357 (VALSTAR 200 mg)</b>
Dose: <b>800 mg intravesically 1X week for 6 weeks</b>	
Known Allergies & Health Conditions:	

**HEALTHCARE PROVIDER INFORMATION**

Healthcare Provider Name:		Specialty:	Can we contact your patient? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Street Address:		City:	State:	Zip:
Contact Name:	Phone #:	Secure Fax #:	Office Hours:	
DEA #:	Tax ID #:	NPI #:	Medicare Provider #:	Other Provider # s:

**Prescription Authorization / Certification of Medical Necessity / Authorization to Release Patient Information**

By signing this form, you are a) authorizing the dispensing of the above prescription, b) certifying that the therapy above is medically necessary, and c) certifying that you have received from the patient identified above, or his personal representative, the necessary authorization to release, in accordance with applicable federal and state privacy laws and regulations, referenced medical and/or other patient information relating to the need for VALSTAR® therapy to Endo Pharmaceuticals and its agents or contractors for the purpose of seeking information related to coverage for VALSTAR® therapy and/or assisting in initiating or continuing VALSTAR® therapy.

**Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

This patient authorization expires 5 years from the acknowledgment date

R<sub>x</sub> only

VALSTAR® is a registered trademark of Endo Pharmaceuticals.



CHADDS FORD, PENNSYLVANIA 19317

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