tyrvaya® (varenicline solution) nasal spray 0.03 mg

Prescription Fax Order Form

PhilRx Pharmacy

TEAM tyrvaya™ PATIENT SUPPORT

Fax this completed Prescription Form to PhilRx: 888-975-0603

Patient Information

Name: _____ Date of Birth *(MM/DD/YYYY)*: _____

Cell Phone: (_____) _____ Email: _____

Shipping Address: _____ City: _____ State: _____ Zip: _____

Sex: ◯ Male ◯ Female Primary Language: _____

Prescriber Information

Name: _____ NPI #: _____

Address: _____ City: _____ State: _____ Zip: _____

Office Contact Name: _____

Phone: (_____) _____ Fax: (_____) _____ *(for prescription status updates)*

Tyrvaya Prescription Information

Strength/Form	Quantity	How Supplied	Refills	Dosage/Administration Instructions
Tyrvaya (varenicline solution) nasal spray 0.03 mg/spray	8.4 mL	One carton for 30 days	_____	1 spray in each nostril twice a day, approximately 12 hours apart
	25.2 mL	3 cartons for 90 days	_____	1 spray in each nostril twice a day, approximately 12 hours apart

ICD-10 or Diagnosis: _____

Prior Medication Trials/Failures*
(treatment name, duration, and reason for discontinuation): _____

*If applicable.

Insurance Information *(Please attach a copy of the front and back of the patient's insurance card **OR** fill out the information below)*

Check the box that applies: ◯ Commercial/Private ◯ Medicare Part D ◯ Medicaid ◯ Other ◯ Uninsured

Member Name *(cardholder)*: _____ Rx Plan Name: _____

Prescription Drug Card Member ID #: _____ Rx Group: _____

RX BIN: _____ RX PCN: _____

Prescriber Signature: _____ Date: _____

Transmitted by *(full name if other than prescriber)*: _____

Have questions or need assistance?

Call the dedicated prescriber line at 855-544-1850 to speak with a PhilRx Support Representative or contact your Viatris representative.

VIATRIS™