KLISYRI® (tirbanibulin) Referral Form

PHONE: 888-412-9325 FAX: 877-329-9325 eRx NPI: 1093424905 www.zealsp.com

Zeal Specialty Pharmacy

Remove above portion before faxing. Please complete the form in its entirety and fax with requested clinicals to the number above.

KLI25-01

PATIENT INFORMATION

First Name	Last Name	Date of Birth ____ /____ / ____	Gender ☐ Male ☐ Female
Address	City	State	Zip
email	Home Phone	Cell Phone	

PRESCRIBER INFORMATION

Prescriber Full Name		Prescriber Credential	
Practice Address	City	State	Zip
Office email	Office Phone	Office Fax	Cell Phone
Practice Contact Person	Prescriber NPI	Preferred Contact Method ☐ Email ☐ Phone ☐ Fax	

CLINICAL INFORMATION – *please include any relevant office visit/lab notes to support this prescription*

Patient is ☐ Naïve / New Start ☐ Therapy Restart ☐ Existing Treatment | Therapy Start Date ____ /____ / ____

Allergies ☐ NKDA ☐ Drug Allergies (please list)

Therapies Tried and Failed (please check name and include dates)

☐ Fluorouracil (Carac 0.5%, Efudex 5%, Fluoroplex 1%, Tolak 4%) Date ____ /____ / ____

☐ Imiquimod Cream (Aldara 5%, Zyclara 3.75%, Zyclara Pump 2.5%, 3.75%) Date ____ /____ / ____

☐ Diclofenac Date ____ /____ / ____

☐ Photodynamic Therapy Agents Date ____ /____ / ____

☐ Other: Date ____ /____ / ____

Current Medications (please list name and dose)

ICD-10 Code ☐ L57.0 Actinic keratosis
☐ Other: _____

Indication Demographics:
Site of Lesion(s) ☐ Face ☐ Scalp ☐ Both

Reason for therapeutic failure/therapy not tried

☐ Patient requires field therapy (i.e. not spot treatment)
☐ Adverse Reactions (local skin reaction, photosensitivity, ocular reaction)
☐ Adherence concerns
☐ Hypersensitivity to aspirin and/or NSAID products
☐ Disease contraindication (DPD)
☐ Previous Coronary Artery Bypass Graft Surgery
☐ Increased risk of bleeding
☐ Increased risk of serious cardiovascular thrombotic effects

PRESCRIPTION – *please check all boxes across row*

Medication	Dose/Strength	Directions	Quantity	Refills
☐ **KLISYRI®** (tirbanibulin)	☐ 250 mg (25 cm^2 or less) ☐ 350 mg (100 cm^2 or less)	Apply KLISYRI to the treatment field on the face or scalp once daily for 5 consecutive days using 1 unit-dose packet per application.	☐ 5 unit-dose packets ☐ _____	☐ 0 ☐ 1 ☐ _____

By signing below, I authorize the pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.
I also certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

Prescriber's signature: _____ ☐ MD ☐ DO ☐ PA ☐ CRNP **Date:** ____ /____ / ____

NO STAMPS

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" on the prescription.

Note: *The information contained in this document will become a legal prescription. Prescriber is to comply with all state-specific Pharmacy and Medical Board guidelines such as e-prescribing, state specific prescription form, fax language, number of prescriptions allowed on a single prescription form, etc. If more than one page is required, make additional copies. Non-compliance with state-specific requirements could result in outreach to the prescriber.*

SHIPPING INFORMATION

Ship to: ☐ Patient ☐ Physician/Clinic | Date Shipment Needed By: ____ /____ / ____