LOQTORZI™ (toripalimab-tpzi) injection

Call 1-844-483-3692
Monday–Friday 8 AM to 8 PM ET
FAX 1-877-226-6370
www.LOQTORZISolutions.com

Patient Assistance Program Product Request Form

All fields are required unless otherwise indicated.

Date ____/____/____

PATIENT

First Name ______________ Last Name ______________ DOB ____/____/____

TREATING PROVIDER

First Name ______________ Last Name ______________ Title ______________

Office Contact ______________ Name ______________

Phone ______________ Email ______________ (not required)

Delivery Address ______________

City ______________ State ________ ZIP ______________

PLEASE COMPLETE AND RETURN TODAY TO AVOID PRODUCT SHIPMENT DELAY FAX Number: 1-877-226-6370

1. **Is the patient in need of PAP replenishment?** ☐ YES ☐ NO
   a. Providers requesting more than six (6) PAP fills of of LOQTORZI™ (toripalimab-tpzi) for the same patient will be required to provide written attestation reaffirming continued PAP necessity (DX, patient therapy log, hardship, etc.)

3. **Has there been a change in the patient's insurance coverage since the last treatment?** ☐ YES ☐ NO
   a. If YES, please provide the following information:

   Insurance Name: ______________

   Insurance ID: ______________ Insurance Phone: ______________

4. **When is the patient's next treatment date?** ____/____/____

5. **Please provide any additional comments below:**

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If you have any questions, please call LOQTORI Solutions™ at 1-844-483-3692, Monday through Friday, 8AM to 8PM ET.

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