

*Indicates required field

PRESCRIPTION INFORMATION

*Patient Name (Last, First)		*Date of Birth	*Gender <input type="checkbox"/> M <input type="checkbox"/> F	
*Address (Cannot be a PO Box)		*City	*State	*Zip
*Home Phone	*Cell	*Email		
Emergency Contact		Phone		
Device <input type="checkbox"/> gammaCore Sapphire		Refill Card <input type="checkbox"/> gammaCore Sapphire Refill Card		
*Date	*Days Supply 31	*Quantity 1	*Refill Card Refills	
Prescriber Signature		Date		

PRIMARY PRESCRIPTION INSURANCE

(1) Fill in fields with pharmacy insurance information (NOT medical), OR
 (2) Fax Patient Demographic Information or Patient Insurance Card along with enrollment form.

*Insurance Name	Pharmacy Help Desk Phone
Policy Holder Name	*Relationship to Patient
*Member ID	*Group ID
*Rx BIN	*PCN

PRESCRIBER INFORMATION

*Prescriber Name (Last, First)	*NPI		
*Prescriber's Primary Specialty <input type="checkbox"/> Neurology <input type="checkbox"/> Other			
*Prescriber Phone	*Fax		
*Address	*City	*State	*Zip
Email	Tax ID	DEA	

PRESCRIBER OFFICE CONTACT INFORMATION

*Office Contact Name (Last, First)	*Email	*Phone
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CLINICAL INFORMATION

*Diagnosis	
<input type="checkbox"/> G43.709 - Chronic migraine without aura, not intractable, without status migrainosus	<input type="checkbox"/> G44.011 - Episodic cluster headache, intractable
<input type="checkbox"/> G43.719 - Chronic migraine without aura, intractable, without status migrainosus	<input type="checkbox"/> G44.021 - Chronic cluster headache, intractable
<input type="checkbox"/> Other _____	
History of, or at risk for, severe allergic reaction to:	

Terms and Conditions

CO-PAY ASSIST

1. This offer is valid for commercially-insured patients and is good for use only with a gammaCore Sapphire or gammaCore-S prescription at the time the prescription is filled. **2. Depending on your insurance coverage, eligible insured patients will receive up to \$100 of assistance for their monthly out of pocket costs for up to 12 months of treatment prescribed with a gammaCore Sapphire or gammaCore-S device.** Check with your pharmacist or healthcare provider for your copay discount. Patient out-of-pocket expense may vary. **3.** This offer is not valid for patients enrolled in Medicare, Medicaid, or other federal or state healthcare programs, including a state medical or pharmaceutical assistance program, or private indemnity or HMO insurance plans that reimburse you for the entire cost of your prescriptions or if you are covered by insurance in states that have an all-payer anti-kickback law or insurance that is paying the entire cost of the prescription. **4.** Patients may not participate in this offer while receiving any additional co-pay assistance or charitable organization support for gammaCore. **5.** Each offer is valid for up to 12 months of gammaCore Sapphire or gammaCore-S prescription treatment. An explanation of benefits statement must be faxed in before each use to verify the benefit needed. **6.** Offer only valid for patients 18 or over. **7.** Limit of 1 offer per patient. **8.** electroCore reserves the right to rescind, revoke, or amend this offer without notice. **9.** Offer good only in the USA, including Puerto Rico, at participating pharmacies or healthcare providers. **10.** Offer void in Massachusetts. **11.** Void if prohibited by law, taxed, or restricted. **12.** This offer is not transferable. **13.** This offer is not insurance. **14.** By redeeming this offer, you acknowledge that you are an eligible patient and that you understand and agree to comply with the terms and conditions of this offer.



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