OTONOMY ANSWERS™

INTAKE FORM

Phone: 1-844-684-7746 Fax: 1-800-418-0274

1 REQUESTED SERVICES *(check all that apply)*

☐ **Benefit Investigation:** An Otonomy Answers™ reimbursement specialist will contact the patient's insurer to collect information on benefits and reimbursement for OTIPRIO® (ciprofloxacin otic suspension) 6%.

☐ **Prior Authorization Support:** An Otonomy Answers reimbursement specialist will provide information on the prior authorization submission process to the patient's insurer and conduct necessary follow-up with the insurer until a decision is rendered.

☐ **Appeals Support (please include denial letter if available):** An Otonomy Answers reimbursement specialist will provide information on the appeal submission process to the patient's insurer and conduct necessary follow-up with the insurer until a decision is rendered.

☐ **Claim Review (please include EOB and original claim form):** An Otonomy Answers reimbursement specialist will review a patient claim to identify potential billing errors. This may also include calling the patient's insurer to obtain additional information about the claim and its adjudication.

☐ **Other (please specify):**

2 PATIENT INFORMATION

Patient Name:	Date of Birth:	Gender: ☐ Male ☐ Female	SSN:
Address:	City:	State:	Zip Code:
Primary Contact:	Relationship:	Phone Number:	

3 PATIENT INSURANCE INFORMATION *(include a copy of the patient's insurance card, front and back)*

☐ Patient Is Insured ☐ Patient Is Uninsured *(does not have health insurance)*

PRIMARY Insurance Name:		
Plan Name:		Phone Number:
Policyholder Name and Relationship to Patient:		
Policy Number:	Group Number:	Member ID Number:

SECONDARY Insurance Name:	
Plan Name:	Phone Number:
Policyholder Name and Relationship to Patient:	
Policy Number and/or Member ID Number:	Group Number:

4 REQUESTOR INFORMATION *(person requesting services and will serve as primary contact)*

Requestor's Name:		Title:
Name of Office or Facility Requestor Is Affiliated With:		
Phone Number:	E-mail:	Fax Number:

OTONOMY ANSWERS™

5 PRESCRIBER AND FACILITY INFORMATION

Prescriber Name:				
Facility Name:			☐ HOPD ☐ ASC ☐ Physician Office	
Address:	City:		State:	Zip Code:
Facility Tax ID:	Prescriber Tax ID:		Prescriber NPI:	
PTAN (Medicare only):	Medicaid Provider ID (Medicaid only):			

6 MEDICAL INFORMATION *(must be completed by healthcare professional)*

Patient Diagnosis (primary):

Patient Diagnosis (secondary):

Date of Tympanostomy Tube Placement Surgery (actual, scheduled, or anticipated):

To the best of my knowledge the patient is clinically appropriate for OTIPRIO® (ciprofloxacin otic suspension) 6% based on its FDA-approved indication.
Initial here: __________

7 CERTIFICATION

By signing this form, I certify that I am either the prescribing physician or I am a duly authorized representative of the prescribing physician or the facility listed in Section 5 above that is requesting the services identified in Section 1 above. I certify that I or the prescribing physician or the facility listed in Section 5 above have received consent from the patient and/or the patient's legal guardian and met any other applicable requirements imposed under the Health Insurance Portability and Accountability Act of 1996 and any applicable state laws needed to release the above information, as well as other personal and health information of the patient, to McKesson Specialty Arizona, Inc. and its affiliates ("McKesson") for the purposes of performing the services requested in Section 1 above and other related services which may include, without limitation, verifying the patient's insurance coverage and obtaining coverage and reimbursement. I further certify that if the consent is withdrawn I will immediately notify McKesson of the withdrawn consent.

SIGN HERE	AUTHORIZED SIGNATURE	DATE
HANDWRITTEN NAME AND TITLE		

INSTRUCTIONS:

1. This Intake Form must be completed for all interactions involving patient-identified information.
2. Complete all applicable sections of the Intake Form.
3. Fax the completed and signed Intake Form and all required documentation to Otonomy Answers at the fax number: 1-800-418-0274.
4. If preferred, an Otonomy Answers reimbursement specialist will reach out to the contact listed on the Intake Form in Section 4.
5. For questions, please call Otonomy Answers at 1-844-684-7746 Monday through Friday, from 8 AM to 8 PM ET (except holidays).

PATIENT CONFIDENTIALITY: Patient confidentiality is of primary importance to us. All patient information will remain confidential. Information may be provided to clinicians, payers, social workers, or family members when required as necessary to perform the services in Section 1.

IMPORTANT REMINDER: Please be certain that all applicable pages of the Intake Form are completed and include all appropriate documentation when submitting the form. Incomplete forms slow the review process and, in some cases, may require resubmission.

©2016 Otonomy, Inc. All rights reserved.
OTIPRIO is a registered trademark and Otonomy Answers is a trademark of Otonomy, Inc.
1-OTI16205