



Mail your original prescriptions with this Enrollment Form or have your doctor fax them directly to 1-866-909-5171.

Once we begin to fill your prescriptions you may order refills 24 hours/7 days a week by calling 1-866-909-5170 or TTY 711 (M-F 8am-10pm Saturday 8am-4:30pm) to speak with a representative or our automated system. You may also order refills on-line at our website at [www.orchardrx.com](http://www.orchardrx.com)

### SPECIAL HANDLING

\_\_\_\_\_ Please initials on this line if you do NOT want child-proof caps mailed to your household. Snap caps or easy off lids will be sent with your medications if this line is initialed.

**GENERICS:** Orchard Pharmaceuticals will automatically dispense the generic drug unless your prescriber writes "D A W" (dispense as written) on the prescription and the brand name drug is medically necessary. Brand name drugs typically require you to pay a higher co-payment.

### USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Health Insurance Portability and Accountability Act of 1996 states that you have the right to have one or more persons act as your representative to make decisions about the uses and sharing of your protected health information. You can limit the amount of protected health information that the authorized personal representative(s) can decide about, and you can cancel this at any time.

### DESIGNATION OF PERSONAL REPRESENTATIVE

I, (Name) \_\_\_\_\_ (Date of Birth) \_\_\_\_ / \_\_\_\_ / \_\_\_\_ hereby name the following person to act as my authorized personal representative with respect to decisions involving the use and/or sharing of protected health information that pertains to me.

\_\_\_\_\_  
(Print Name of Personal Representative)

\_\_\_\_\_  
(Relationship of Personal Rep to Member)

\_\_\_\_\_  
(Phone Number of Personal Representative)

**PLEASE CHECK ONLY ONE BELOW:**

The person named above is to be given all of the privileges that would be given to me with respect to my protected health information;

**OR**

The person named above is acting as my designated personal representative ONLY for the following function(s): \_\_\_\_\_

I understand that I may cancel this designation at any time by contacting Orchard at **1-866-909-5170** or TTY 711 (M-F 8am-10pm Saturday 8am-4:30pm). I understand any cancellation can only apply to future disclosures or actions regarding my protected health information and cannot cancel actions taken or disclosures made while the designation was in effect.

**SIGNATURE:**

**DATE:**