# EXPAREL Enrollment Form

Fax completed enrollment form to 1-866-329-9775

Call us at 1-844-462-6225, Monday - Friday, 8 AM - 8 PM ET

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Note: Fields marked with * are required.

## 1A. Patient Information

Last name*: ______________________ First name*: ______________________

Address*: ______________________ City*: ______________ State*: ______ ZIP*: ________

Cell phone #: ______________ Home phone #: ______________ Email: ______________

Gender*: ❑ Male ❑ Female Date of birth*: _____/_____/_____ Preferred time to contact: ❑ AM ❑ PM

## 1B. Insurance Information

**Attach a copy of both sides of the patient's medical and/or dental insurance card(s) and/or fill out the insurance information below.**

Is the patient enrolled in a government-funded healthcare program such as Medicare, Medicaid, VA, DoD, TRICARE, a qualified health plan (QHP), or a plan offered under a state or federal exchange?* ❑ Yes ❑ No

**Primary Insurance**

Plan name*: ______________________

ID #*: ______________ Group #: ______________

Plan phone #*: ______________________

Policy holder: ______________________

Date of birth of policy holder (if different from patient): _____/_____/_____

Relationship to patient: ______________________

**Secondary Insurance**

Plan name: ______________________

ID #: ______________ Group #: ______________

Plan phone #: ______________________

Policy holder: ______________________

Date of birth of policy holder (if different from patient): _____/_____/_____

Relationship to patient: ______________________

## 2A. Treating Provider Information

Treating provider name and credentials (if known): ______________________

NPI #*: ______________ State license #: ______________ Tax ID #: ______________ DEA #: ______________

Office name: ______________________

Address*: ______________________ City*: ______________ State*: ______ ZIP*: ________

Phone #*: ______________________ Fax #*: ______________________

**Primary Contact** Preferred method of contact: ❑ Phone ❑ EXPARELSupport.com

Contact name: ______________ Email: ______________ Phone #: ______________

## 2B. Treating Facility Information

Treating facility name: ______________________ Facility NPI: ______________

Address*: ______________________ Phone #: ______________

Place/Site of service: ❑ 11-Physician office/clinic ❑ 24-Ambulatory Surgery Center ❑ 19-Hospital Outpatient Department (Off-campus) ❑ 22-Hospital Outpatient Department (On-campus)

## 3. Diagnosis and Clinical Information

Treatment date: _____/_____/_____ ❑ Quantity: ________ 133mg/10ml vial ________ 266mg/20ml vial

Surgical procedure: ______________________

Treatment area: ______________________

ICD-10 code: ______________________ CPT/CDT: ______________________

## 4. EXPAREL Indication for Use

EXPAREL® (bupivacaine liposome injectable suspension) is indicated to produce postsurgical local analgesia via infiltration in patients aged 6 years and older and regional analgesia in adults via an interscalene brachial plexus nerve block, sciatic nerve block in the popliteal fossa, and an adductor canal block. Safety and efficacy have not been established in other nerve blocks.

## 5. Physician Authorization

By signing below, I certify that (1) the above therapy is medically necessary and in the best interest of the patient listed above; (2) the information provided is complete and accurate to the best of my knowledge; (3) I have obtained any and all authorizations and consents from the patient or the patient's authorized personal representative necessary under HIPAA and state law to release protected health information, including that contained on this form, to Pacira BioSciences and its contractors and business partners ("Contractors") for purposes relating to the EXPAREL® Patient & Provider Services, to solely assist with benefits verification, prior authorization/appeals assistance, and forwarding the above prescription by fax or other means of delivery to a licensed pharmacy to dispense EXPAREL where appropriate; and [4] I agree to the Business Associate Agreement as presented at EXPARELSupport.com.

**Healthcare professional name (please print):** ______________________

**Healthcare professional signature:** ______________________ Date: _____/_____/_____

**For more information, including Important Safety Information, please visit www.EXPARELpro.com or call 1-855-793-9727. By submitting this form, you indicate that you read, understand, and agree to our privacy policy at www.EXPARELpro.com/privacy-notice.**

PACIRA BIOSCIENCES, INC.

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EXPAREL® (bupivacaine liposome injectable suspension)