VIZAMYL™ Flutemetamol F18 Injection

Patient Referral Form

Live Support (844) 225-1595 (Mon–Fri, 8 am to 6 pm ET)
Fax (844) 225-1596

Patient Information *(required)*

Patient Name:		DOB:	Sex: ☐M ☐ F
Address:		City:	State: ZIP:
Home Phone:	Cell Phone #:		Email:
Language: ☐ English ☐ Spanish ☐ Other:		Best Time to Contact: ☐ Morning ☐ Afternoon ☐ Evening	

Patient Insurance Information *(required)*

PLEASE INCLUDE COPY OF FRONT AND BACK OF PATIENT'S INSURANCE CARD(S)

Primary Insurance:	Group #:	Policy/MBI #:
Primary's Phone #:	Subscriber's Name *(if not self):*	
Subscriber's Employer:	Subscriber's Relationship to Patient *(if not self):*	
Secondary Insurance:	Group #:	Policy/MBI #:
Secondary's Phone #:	Secondary's Type:	

Prescriber's Information *(required)*

Prescriber's Name:		SLN #:	NPI #:
Practice Name:		Tax ID #:	PTAN/OSCAR#:
Address:		City:	State: ZIP:
Phone #:	FAX:		Email:
Office Contact Name:		Preferred Method of Contact: ☐ Phone ☐ Email ☐ FAX	

Medical Information *(required)* Vizamyl NDC:17156-067-30

ICD-10 Diagnosis Code

- ☐ G30.0 Alzheimer's disease w/early onset
- ☐ G30.1 Alzheimer's disease w/late onset
- ☐ G30.8 Other Alzheimer's disease
- ☐ G30.9 Alzheimer's disease, unspecified
- ☐ G31.84 mild cognitive impairment, so stated
- ☐ OTHER:

Procedure Details *(Check Site of Service)*:

- ☐ Free Standing Imaging Center
- ☐ Hospital Outpatient

Anticipated Date of Service:

Site of Service Details:

Name:
Location:
NPI:
Contact:
Phone #:
Email:

HCPCS/CPT® Code *(Check Code for Positron Emission Tomography (PET):*

☒ Q9982 Flutemetamol F-18, up to 5 millicuries ☐ 78811 Limited Area ☐ 78814 Limited Area w/ CT

Prescriber's Signature *(required)*

By signing below, I certify that (a) the above-prescribed diagnostic procedure is medically necessary and, (b) I have received from the patient identified above, or his/her personal representative, the necessary authorization to release, in accordance with applicable federal and state privacy laws and regulations, referenced medical and/or other patient information relating to the need for the above-prescribed diagnostic procedure, to the Vizamyl Support Program ("Program") through GE HealthCare's authorized Program service provider, its employees, affiliates and their representatives, its business partners, agents, and contractors for the purpose of seeking information related to coverage for the agent and/or related procedure.

Prescriber's Signature:	Date:

GE HealthCare

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