CERIANNA ACCESS SUPPORT℠

Cerianna Support Provider Consent Form

Please contact Cerianna Support at
(833) 946-6392 (Mon–Fri, 8 AM to 6 PM ET) or fax Consent to (833) 718-3297

Check all that apply:

- ☐ BENEFIT INVESTIGATION
- ☐ PEER-TO-PEER ASSISTANCE
- ☐ BILLING AND CODING ASSISTANCE
- ☐ PRIOR AUTHORIZATION ASSISTANCE
- ☐ PRE/POST APPEALS ASSISTANCE
- ☐ CLAIMS ASSISTANCE
- ☐ MEDICAL NECESSITY DOCUMENTATION ASSISTANCE

Patient Information

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

Prescriber's Information

Prescriber's Name:	
Practice Name:	
Address:	
City/State/ZIP:	
Email:	
Phone:	Fax:
Office Contact Name:	
NPI #:	SLN #:
Tax ID #	PTAN:

Setting of Care: ☐ IDTF ☐ Outpatient Hospital ☐ Other (explain):

Insurance Information

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

Primary Insurance:	Policy ID #:
Group #:	Phone #:
Subscriber's Name (If not self):	Employer:

Prescriber contracted w/patient's insurance? ☐ Yes ☐ No

Diagnosis & Clinical Information

☐ Diagnosis (ICD-10 Code / Description):	☐ Other Diagnosis (ICD-10 Code / Description):

Diagnostic Procedure Information

Product Requested	NDC Number
CERIANNA	**72874-0001-01**

Procedure Requested, please check one: ☐ 78815 Skull Base to mid-thigh ☐ 78813 Whole body PET

Please provide name and NPI for imaging center:

Prescriber's Signature

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 Cerianna 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:

PLEASE NOTE: PROVIDER MUST HAVE A SIGNED HIPAA FORM ON FILE FOR THIS PATIENT

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cERianna™ (FLUOROESTRADIOL F 18) INJECTION