Prior to submission

Please complete all required sections of the enrollment form.
Submit by fax to **1-844-339-8515** or email to **support@lantheuslink.com**.

STEP 1
Select the level of support requested.

STEP 2
Provide all required patient information.

STEP 3
Provide all required insurance information. You may attach a copy of the **front and back** of a patient's insurance card(s) instead of filling out this section.

STEP 4
Provide all referring physician information. If you are an imaging center, referring physician information is still required to complete benefits investigation.

STEP 5
Provide imaging location information. Leave blank to have Lantheus Link identify at least three (3) in-network options in the patient's area. Check the box provided if an order has already been sent to the imaging center.

STEP 6
Provide all clinical information. Lantheus Link can only support on-label patients. If the enrollment form is intended to act as an order for the imaging center, include the most recent progress note.

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LantheusLink™
Enrollment Form

Please complete and fax the enrollment form to **1-844-339-8515** or email to **support@lantheuslink.com**. Please note that email communications sent to Lantheus or its third-party service providers may not be encrypted or secured, and safeguards established under the HIPAA Security Rule would not apply to these communications.

1 Support Requested

*Indicates required field.

☐ Patient support and insurance navigation ☐ Patient support only ☐ Insurance navigation only

- Patient support may include identifying an imaging center, appointment reminders, patient education, options for transportation assistance and foundation assistance
- Insurance navigation may include benefits verification, prior authorization assistance, appeal and/or claims assistance

2 Patient Information

*First name		*Last name	
*DOB (MM/DD/YYYY)	Email		
*Address	*City	*State	*ZIP
*Preferred phone number ☐ Home ☐ Mobile	Alternate phone number ☐ Home ☐ Mobile		
Preferred language ☐ English ☐ Spanish ☐ Other	*Preferred contact method ☐ Call ☐ Email ☐ Text		
Best time to contact ☐ Morning ☐ Afternoon ☐ Evening	Okay to leave voicemail ☐ Yes ☐ No		

☐ I give permission to disclose my personal health information to the following authorized representative (optional)

*Authorized Representative Name/relationship

3 Insurance Information

Attach copies of ALL of the patient's insurance card(s)

*Primary medical insurance		*Primary insurance phone number
*Plan type	*Group number	*Policy ID/MBI number
*Subscriber's name/relation (if not self)		*Subscriber's employer (if applicable)
*Secondary medical insurance		*Secondary insurance phone number
*Plan type	*Group number	*Policy ID/MBI number
*Subscriber's name/relation (if not self)		*Subscriber's employer (if applicable)

4 Referring Physician

*First name	*Last name		Practice name
*Address			Practice phone number
*City	*State	*ZIP	Office contact name
Office email			Office contact phone number
*Tax ID number	*Provider NPI number		Office fax number
State license number	Medicare PTAN (Provider transaction access number)		Preferred contact method ☐ Call ☐ Email ☐ Fax

5 Imaging Location

Please leave this section blank if you would like Lantheus Link to assist in finding an in-network imaging center in patient's area

Hospital/imaging center name			☐ Outpatient ☐ Independent scan facility
Address	☐ Please check here if an order has been sent to the imaging location		
Office contact	City	State	ZIP
Office contact phone number	Billing contact		
Office contact email	Billing contact phone number		
Preferred contact method ☐ Call ☐ Email ☐ Fax	Fax number	Anticipated scan date	
Tax ID number	Imaging center NPI number	Medicare PTAN (Provider transaction access number)	

6 Clinical Information

Please include most recent progress note

*ICD-10 diagnosis code(s): ☐ C61 (primary) ☐ C79.82 ☐ Z19.1 ☐ Z19.2 ☐ Z85.46 ☐ R97.21 ☐ *HCPCS code A9595

*Procedure (CPT) code ☐ 78815 ☐ 78816 ☐ Other *CPT modifier ☐ PI (Initial) or ☐ PS (Recurrent)

STEP 7
Ensure patients provide their **signature and the date.** Check the box provided if patients would like to receive program text messages.

7 Permission to Provide Lantheus Link Services

*Indicates required field.

By signing, I enroll in Lantheus Link patient support services ("Services") related to my ordered PET imaging scan using PYLARIFY®, which may include educational resources, case management support, and information on potentially available out-of-pocket cost support. Lantheus Link will gather information about me, including information related to my medical condition and treatment, care management, health insurance and coverage claims, and order for PYLARIFY® and the related PET scan, as well as all information provided on this form (together "My Information"). I understand that Lantheus Link may:

- Review and verify my insurance coverage for my ordered scan.
- Inform me about potentially available transportation and financial assistance options.
- Provide appointment reminders for my ordered scan.
- Share educational and promotional materials about the Services which may be based on the information I provide, including any health information I share on the form above.
- Conduct quality assurance and seek feedback related to the Services.
- Use de-identified information for research and business improvements.

Lantheus Link Services may change at any time. For more information on how we use personal information, please visit Lantheus' Privacy Policy https://www.lantheus.com/legal/privacy-policy/

I can opt out of communications or services at any time by calling 844-339-8514 or emailing support@lantheuslink.com. This will not apply to any prior use of My Information.

☐ **I agree to receive text messages from Lantheus as part of Lantheus Link Patient Support Services.**

By opting in, I consent to receive text messages at the number I provided on this form. Standard message and data rates may apply. Text "STOP" to opt out at any time.

*Patient signature/legal guardian signature	*Date	Printed name/relationship to patient (if applicable)

STEP 8
Ensure patients provide their **signature and the date** to complete the enrollment process.

8 Permission to Share Health Information

By enrolling in Lantheus Link, I authorize my health insurance, physicians, and other healthcare providers ("Providers") to share My Information with Lantheus, its affiliates, and partners to enroll me in Lantheus Link, provide program services and conduct quality assurance and other business activities. Lantheus Link may use my de-identified information for internal analysis or research purposes. I understand that federal privacy laws may not protect My Information from further disclosure once disclosed to Lantheus Link, but Lantheus Link has agreed to only use it as allowed by me in this authorization or required by law. Signing this form is voluntary and will not affect my ability to obtain medical treatment, my eligibility for insurance benefits, or coverage under my health insurance, or access to Lantheus products including a PET scan with PYLARIFY®. Without this authorization, Lantheus Link cannot provide Services to me. Unless revoked, this authorization expires one year from the date signed, or earlier if required by law. I understand that I may revoke this authorization at any time by emailing such cancellation to support@lantheuslink.com or calling 844-339-8514; however, this cancellation will not apply to My Information already used or disclosed before notice of cancellation is received by Lantheus Link. I understand that I am entitled to a copy of this form.

*Patient signature/legal guardian signature	*Date	Printed name/relationship to patient (if applicable)

STEP 9
Sign and date to complete the enrollment process.

9 Physician Legal Consent/Agreement

By signing, I confirm that the patient named on this form is under my care, and the information provided is accurate to the best of my knowledge. The ordered diagnostic procedure, a PET scan using PYLARIFY®, is medically necessary and aligns with FDA-approved labeling. I have obtained written authorization from my patient or their representative, as required by state and federal law, including HIPAA and its implementing regulations, to share the health information on this form with Lantheus Link for: (1) Verifying insurance coverage and eligibility for a PET scan using PYLARIFY®, (2) identifying imaging centers for the ordered scan, and (3) introducing related services to my patient and contacting them for these purposes. I acknowledge that I am not obligated to order any Lantheus products and have not received nor will receive any benefit from Lantheus for doing so. I consent to being contacted by Lantheus Link via fax, phone, mail, or email to assist the above-named patient and/or to provide me with additional program information. I understand that Lantheus may change or end program services without notice.

*Physician signature	*Date

For more information, visit lantheuslink.com or call 844-339-8514.
Please return completed form by fax to 844-339-8515 or email to support@lantheuslink.com.

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Scan to visit our website, explore our services and download the digital enrollment form.

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