COST SUPPORT PROGRAM ENROLLMENT FORM FOR CINQAIR® (reslizumab) Injection 100mg/10mL

Please complete form, sign, and fax to Teva Support Solutions® **1-844-838-2213**
For questions or assistance, please call Teva Support Solutions®, Monday–Friday, 9 AM –5:30PM EST at **1-844-838-2211**

TEVA SUPPORT SOLUTIONS®

PATIENT INFORMATION (Please type or print clearly)

Name (First, MI, Last, Suffix): Date of Birth: Gender: M☐ F☐

Home Address: City: State: ZIP:

☐ Home Phone: ☐ Cell Phone: (please check preferred phone number)

☐ Check to opt out of receiving voicemails

☐ Primary Language Spoken:

INSURANCE INFORMATION (Please complete or provide front and back copies of ALL insurance cards)

Primary Insurance:

Cardholder Name: ID #: Group #: Phone #:

Rx Card Name: ID #: BIN #: PCN #: Group #:

Secondary Insurance:

Cardholder Name: ID #: Group #: Phone #:

Medicare: ☐ A ☐ B ☐ C (Advantage) ☐ D *Note: Specialty Pharmacy acquisition not available for Medicare A & B.*

PATIENT AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

I authorize my healthcare providers, pharmacies and health plan(s) to disclose my personal health information on this form as well as information related to my medical condition, treatment, care management, prescriptions and health insurance to Teva Pharmaceuticals USA, Inc. and its affiliates, contractors and agents, including its third party patient support program service provider (collectively "Teva") for the purposes described below.

I understand that the purpose of this Authorization is to provide me with access to services related to my prescribed medication and/or medical condition ("Program"), including (i) enrollment in the Program; (ii) conducting benefits investigation and coordinating my insurance coverage, which may include allowing a Teva field based representative to access my information and engage with my healthcare providers directly, if necessary; (iii) if needed, determining my eligibility for and coordinating financial assistance; (iv) coordinating prescription fulfillment and product replacement; (v) providing nursing support, including product administration training and education; (vi) facilitating quality and adverse event reporting activities; (vii) conducting data analytics, market research and Program related business activities; (viii) contacting me by direct mail or by electronic or telephonic means to the contact information on this form or to any future contact information provided by me or on my behalf in connection with carrying out the Program services, including adherence related communications, reminders, and support, for which the third party service provider may receive financial remuneration from the manufacturer of your medication.

I understand that I may cancel this Authorization at any time, by writing to Teva, Attn: Authorizations, P.O. Box 7613, Overland Park, KS 66207-9941, but my cancellation will not apply to any information already disclosed pursuant to this Authorization. This Authorization will remain in effect until the Program ends. I understand that once my information is disclosed, it may be subject to redisclosure by the recipients and no longer protected by federal privacy law. I understand that my treatment, payment for treatment, insurance enrollment, or eligibility for insurance benefits will not be directly affected if I do not sign this Authorization. However, if I do not sign this Authorization, I may not be able to receive Program services. I am also entitled to a copy of this signed Authorization.

Patient Sign/date here Date

If signed by someone other than patient, describe legal authority to do so:

PRESCRIBER INFORMATION

Practice Name: Practice Contact Name: Title:

Prescriber Name: Tax ID #:

NPI #:

Practice Mailing Address: City: State: ZIP:

Phone: Fax:

Please check with the patient's payer to verify product coverage, covered infusion locations, and approved acquisition methods.

PRESCRIBER SIGNATURE REQUIRED

I authorize Teva Pharmaceuticals USA, Inc. its affiliates and its designated agents and service providers to provide any information on this form to the insurer of the named patient. I certify that I have a signed copy on file of my patient's current and completed Patient Authorization so that I may share this patient's health information with Teva Pharmaceuticals USA, Inc. I understand that Teva Pharmaceuticals USA, Inc. reserves the right to modify or terminate this Program at any time for any reason without any prior notice. I understand that I am under no obligation to prescribe a specific drug and I have not received, nor will I receive any benefit, for prescribing a specific drug.

Prescriber Sign/date here*

Date

*Signature stamps not acceptable.