PRESCRIPTION AND SERVICE REQUEST 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, 9AM–7PM EST at **1-844-838-2211**

TEVA SUPPORT SOLUTIONS®

SERVICES REQUESTED: (Please check all that apply)
☐ Clinical Nurse Educator ☐ Patient Financial Assistance
☐ Benefits Verification ☐ Coding Information

NON-INFUSING PRESCRIBERS ONLY
☐ Infusion Location Assistance

INFUSING PRESCRIBERS ONLY
Preferred Acquisition Method (subject to Health Plan approval)
☐ Buy-and-Bill ☐ Specialty Pharmacy

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) Email address:
☐ Check to opt out of receiving voicemails Drug Allergies:
☐ Primary Language Spoken: Current Medications:

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.

☐ **By checking this box,** I certify that I am at least 18 years old and consent to receive promotional or educational messages from Teva and its affiliates and agents by direct mail and email, as well as electronic or telephonic means at the telephone number provided on this form using automated technology and/or prerecorded voice messages, to provide me with information regarding severe asthma, Teva products, and programs and to conduct market research. I understand my consent is not a condition of purchase. Additional terms apply: http://www.pssmobileterms.com/.

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 #:
Practice Mailing Address: City: State: ZIP:
Phone: Fax:

PRESCRIPTION INFORMATION

CINQAIR 100 mg/10 mL vial
SIG: Infuse 3 mg/kg intravenously every 4 weeks in 50 mL of sterile 0.9% sodium chloride USP for injection over 20-50 minutes

Weight-Based Dosing Calculation: Patient weight (the day of infusion) in kg x 3 mg = # of mg to infuse every 4 weeks

Patient weight:_____kg Infuse:_____mg every 4 weeks Dispense:_____100 mg vials (100 mg/10 mL) Refill:_____times

Diagnosis: ICD-10 Code: _____ _____ Blood EOS Count:_____cells Blood EOS Test Date:_____

ADMINISTRATION

Site of Administration: ☐ Prescribing Physician's Office ☐ Non-Prescribing Physician's Office ☐ Hospital Outpatient ☐ Infusion Center ☐ Home Infusion ☐ Other:

If preferred administration site has a different address than the prescribing physician's practice above, please complete the following:

Name of Preferred Site of Administration or Home Infusion Company:
Contact Name: Phone: Fax: NPI #:
Address: City: State: ZIP:

PRESCRIBER SIGNATURE REQUIRED

I authorize Teva Pharmaceuticals USA, Inc., its affiliates and its designated agents and service providers, including but not limited to CINQAIR® dispensing pharmacies, to provide any information on this form to the insurer of the named patient and to forward the above prescription, by fax or by other mode of delivery to the pharmacy and site of care chosen by the named patient. If this prescription is being shipped by the pharmacy to my office for administration, I agree to accept the medication on behalf of the above named patient.

Prescriber Sign/date here*

Dispense as written **Date**

NPI #:_____

*Signature stamps not acceptable. Please attach all prescriptions on Official State Prescription form if mandated by individual state laws.