Hospital Pharmacy Authorization Form

PROMACTA® CARES™
(eltrombopag)

This Hospital Pharmacy Authorization Form must be completed before your pharmacy/pharmacies can dispense PROMACTA. PROMACTA is available only through a mandatory restricted distribution program called PROMACTA *CARES.*

Please fax this form to 1-866-765-0920. You will receive confirmation of authorization. For questions call 1-877-9-PROMACTA (1-877-977-6622).

Hospital Pharmacy Name:______________________________

Pharmacy Setting:
❑ Inpatient
❑ Outpatient

Identification Number (Enter One):

DEA _______________ NPI _______________ NCPDP _____________

Ship to Address: ______________________________

City: ______________________________ State: _______________ ZIP: _______________

Phone Number: ______________________________ Fax: ______________________________

Primary Contact: ______________________________

E-mail: ______________________________

Primary Wholesaler or Distributor: ______________________________

Address: ______________________________

City: ______________________________ State: _______________ ZIP: _______________

Phone Number: ______________________________ Fax: ______________________________

E-mail : ______________________________

Account #: ______________________________

Note: If you have multiple shipping sites please complete a separate authorization for each ship site.

By signing below, you and all pharmacists in your pharmacy will comply with the following:

- I understand that PROMACTA is only available through PROMACTA *CARES*. I understand that only prescribers enrolled in PROMACTA *CARES* can prescribe PROMACTA and only patients enrolled in PROMACTA *CARES* can be dispensed PROMACTA.
- I will train and provide educational materials to appropriate staff responsible for dispensing PROMACTA. The materials will address the safe and appropriate use of PROMACTA, program monitoring requirements, program adverse event reporting requirements and documentation requirements.
- I will confirm the prescriber and patient are enrolled in PROMACTA *CARES* with each prescription/refill.
- I will verify whether the patient is authorized to receive PROMACTA prior to dispensing each prescription/refill by calling 1-877-977-6622 to receive the unique prescription verification number. I will record the verification number on the Inventory Tracking Log. If a prescription verification number is not provided, PROMACTA cannot be dispensed.
- I will provide a Medication Guide each time I dispense PROMACTA.
- I will maintain and complete the Inventory Tracking Log for every prescription/refill dispensed.
- I understand that each pharmacy site is required to submit the completed Inventory Tracking Log within 10 days of the last day of each month to PROMACTA *CARES*. I will retain a copy of the Inventory Tracking Log for at least 2 years from the date of the final log entry.
- I will cooperate with periodic audits to assure that PROMACTA is dispensed in accordance with the program requirements.

______________________________ Authorized Pharmacy Representative Signature

______________________________ Date

Print Name: ______________________________

Title: ______________________________

Phone Number: ______________________________ E-mail Address: ______________________________

If you have any questions, please contact 1-877-9-PROMACTA (1-877-977-6622) or visit www.PROMACTACARES.com.
Note: Prescribers must also be enrolled in PROMACTA *CARES* in order to prescribe PROMACTA.

gsk GlaxoSmithKline

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