

PATIENT INFORMATION	Patient Information (Please print)	
	Full Name: _____	
	Date of Birth: ____/____/____	PROMACTA CARES Patient ID#: _____
	Date of enrollment in PROMACTA CARES: ____/____/____	Diagnosis and date of diagnosis: ____/____/____
	ICD-9 Code: _____	
Is the patient still under your care? <input type="checkbox"/> Yes <input type="checkbox"/> No If NO, please provide contact information for the new prescriber, if available: _____		Do you authorize the continuation of treatment with PROMACTA for the next 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No

PRESCRIBER	Prescriber Information (Please print)
	Full Name: _____ Phone: _____

Dear <MD Name>
Our records indicate that <patient>'s authorization to receive PROMACTA will expire on <MM/DD/YYYY> and he/she will no longer be able to receive PROMACTA. In order to prevent interruption of <patient>'s treatment with PROMACTA, fax the completed form to _____ at 1-866-765-0920 by <expiration date> and place a copy in the patient's medical record.

TREATMENT/DISCONTINUATION INFORMATION	Is the patient currently receiving PROMACTA? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, go to Safety Section. If NO, see below.			
	If "NO", Reason for Discontinuation: <input type="checkbox"/> Loss of response <input type="checkbox"/> Adverse event (specify): _____ <input type="checkbox"/> Lack of response <input type="checkbox"/> Death: Cause of Death: _____ Date Deceased: ____/____/____ <input type="checkbox"/> Lost to follow-up <input type="checkbox"/> Other (specify): _____	If "NO", Stop Date: ____/____/____	If "NO", Last Dose Administered: _____ mg <input type="checkbox"/> QD <input type="checkbox"/> QOD	If "NO", Platelet Count Upon Discontinuation: _____ (x10 ⁹ /L)

SAFETY INFORMATION	In the past 6 months, has the patient experienced any of the following Serious Adverse Events* not already reported to GSK?		
	Liver abnormality:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Under Investigation
	Thrombosis or thromboembolism:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Under Investigation
	Bone marrow reticulin:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Under Investigation
	Bone marrow fibrosis:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Under Investigation
	New hematological malignancies:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Under Investigation
Progression of previously diagnosed hematological malignancies:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Under Investigation	

SERIOUS ADVERSE EVENTS	Has the patient experienced any additional serious adverse events in the past 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No
	If YES, specify: _____ _____
Was the adverse event reported to GSK? <input type="checkbox"/> Yes <input type="checkbox"/> No	

REPORTER INFORMATION	Reporter Name/Title (Print)	Date of report: ____/____/____
	<input type="checkbox"/> PROMACTA CARES Specialist	SIGNATURE _____
	<input type="checkbox"/> Healthcare Provider	

* An adverse event is SERIOUS (SAE) when the patient outcome is: 1) Death – 2) Life threatening – 3) Hospitalization – initial or prolonged – 4) Significant disability/incapacity 5) Congenital anomaly/birth defect - 6) Other (important medical events)

Please fax this completed form to **PROMACTA CARES** at 1-866-765-0920.
For questions regarding **PROMACTA CARES**, call 1-877-9-PROMACTA (1-877-977-6622).