

Patient Enrollment Form

This Patient Enrollment Form must be completed before you can receive PROMACTA. PROMACTA is available only through a mandatory restricted distribution program called PROMACTA CARES.

PROMACTA[®] CARES[™]
(eltrombopag)

PATIENT

Patient Information (Please Print)

Full Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Treated In: Inpatient setting Outpatient setting

Date of birth: ____/____/____ Gender: M F Preferred Time to Contact: Day Evening

Preferred Phone: _____ Alternate Phone: _____ E-mail: _____

Patient Identification Number (Completed by the
Coordinator for PROMACTA CARES)

PRESCRIBER

Prescriber Information (Please Print)

Treating Healthcare Provider: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____ E-mail: _____

Patient Acknowledgement

- I have read and understand the Medication Guide for PROMACTA that my prescriber has given to me.
- I have asked and discussed any questions or concerns about PROMACTA or my treatment with my healthcare provider.
- I am aware that PROMACTA is associated with the following risks:
 - PROMACTA may damage my liver and cause serious illness or death. I must have blood tests to check my liver before I start taking PROMACTA and during treatment with PROMACTA.
 - Long-term use of PROMACTA may cause changes in my bone marrow. These changes may lead to abnormal blood cells or my body making less blood cells.
 - When I stop receiving PROMACTA, my low blood count may become worse than before I started receiving PROMACTA. This increases my risk for having a serious bleed. These effects are most likely to happen shortly after I stop PROMACTA or within 4 weeks of stopping PROMACTA.
 - I have a higher chance of getting a blood clot if my platelet count is too high during treatment with PROMACTA.
 - PROMACTA may worsen blood cancers and is not approved for use in patients with blood cancer or a precancerous condition called myelodysplastic syndrome (MDS).
- I will report any adverse events to my prescriber.
- I understand that I should not discontinue PROMACTA without talking to my healthcare provider.
- I understand that in order to receive PROMACTA, I am required to enroll in the risk management component of the PROMACTA CARES Program. My healthcare provider will monitor how I am doing on PROMACTA and report to PROMACTA CARES every 6 months about certain serious side effects, and make sure PROMACTA is right for me.
- I understand that my healthcare provider will disclose personal and medical information about me to GlaxoSmithKline, its agents or contractors (together, "GSK"). Such information, to the extent permitted by applicable law, will be used by GSK and disclosed to third parties (e.g., Food and Drug Administration) in order to better understand the safety and effectiveness of PROMACTA. Further, such information (after being de-identified of my personal information) will be used by GSK to evaluate patient enrollment in, and the administration of, PROMACTA CARES.
- I understand that, if I do not sign this Patient Enrollment Form, I will not be enrolled in the mandatory risk management component of PROMACTA CARES and will not receive PROMACTA.
- I understand that GSK, its agents and contractors may contact me via phone, mail, or e-mail to survey me on the effectiveness of the program requirements for PROMACTA CARES.

Patient/Guardian (Please Print): _____

Patient/Guardian Signature: _____ Date ____/____/____

Please fax this completed form to PROMACTA CARES at 1-866-765-0920.

You will receive enrollment confirmation via fax within 1 hour during 8:30AM-8:00PM M-F Eastern Standard Time.

For questions regarding PROMACTA CARES, call 1-877-9-PROMACTA (1-877-977-6622).

