PROMACTA *CARES* Prescription and Reimbursement Services Form (OPTIONAL)

PROMACTA® CARES™
(eltrombopag)
25mg, 50mg tablets

Instructions: Complete pages 1 and 2, tear along perforation and fax.

TO BE COMPLETED BY PATIENT

Patient Information (Please Print)

Full Name: ______________________ Phone: ______________

Address: ______________________ Cell (optional): ______________

City: ______________ State: ______ ZIP: ________ Date of birth: ____ /____ /____

Insurance (Please Print) *Complete only if requesting Reimbursement Services.*

Primary Rx Insurer: ______________________ Phone: ______________

Policy ID #: ______________________ Group #: ______________

Subscriber Name: ______________________ Date of birth: ____ / ____ / ____

Secondary Rx Insurer: ______________________ Phone: ______________

Policy ID #: ______________________ Group #: ______________

Subscriber Name: ______________________ Date of birth: ____ / ____ / ____

Financial Information (Complete only if you want help to determine eligibility for other sources of coverage or assistance)

Current household income: ____________ # of family members who rely on that income: ________

PATIENT CONSENT/AUTHORIZATION: I verify that the information provided herein is true and correct. I understand that the collection, use, and disclosure of my health information are protected under law. Information contained in this Form, such as my name, address, insurance information, prescription/medical information, is "protected health information." See page 2 of 2 for more information. By signing below, I agree to the collection, use, and disclosure of my protected health information to coordinate the delivery of PROMACTA to me.

Signature of Patient or Patient Representative: ______________________ SIGN HERE ←

Name (print): ______________________ Date: ____ / ____ / ____

(If signed by representative, explain authority to act for the Patient.)

Preferred language (if not English): Spanish ❑ Other ______________

TO BE COMPLETED BY PRESCRIBER

Prescription Fulfillment

Will PROMACTA be dispensed from your facility? ❑ **Yes** (skip to Site Contact Information) ❑ **No** (continue below)

Specialty Pharmacy

PROMACTA is available from multiple **authorized** specialty pharmacies through the PROMACTA *CARES* program. A complete list of PROMACTA **authorized** specialty pharmacies is available at www.PROMACTACARES.com. Unless patient requests otherwise, the prescription will be directed to the authorized specialty pharmacy that provides the lowest cost-sharing for patient. If more than one specialty pharmacy is found, a specialty pharmacy will be selected for patient based on uniformly applied selection criteria.

❑ No preference. Please direct prescription to the authorized specialty pharmacy that provides the lowest cost-sharing for patient. If more than one specialty pharmacy is found, a specialty pharmacy will be selected based on uniformly applied selection criteria.

❑ Please direct prescription to the following authorized specialty pharmacy providing this specialty pharmacy offers the lowest cost-sharing option for patient:

____

(Note: If a specialty pharmacy is found to offer a lower cost-sharing option for the patient than the specialty pharmacy named above, the prescription will be directed to specialty pharmacy offering the patient the benefit of a lower cost)

Where would you like your patient's PROMACTA sent via express delivery?

❑ Directly to my patient at the address listed above.

❑ Other address if the address listed above is a post office box: ______________

❑ To my office at the site address listed below (under Site Contact Information):

Diagnosis: ______________ **ICD-9 Code (optional):** ______________

Prescription for PROMACTA: ❑ PROMACTA 50 mg ❑ PROMACTA 25 mg

Total Daily Dose: ________ Quantity: ________ Refills: ________

Dosing Instructions (Sig): ______________________

Signature: ______________________ SIGN HERE ←

SITE CONTACT INFORMATION

SITE CONTACT INFORMATION

Prescriber Name: ______________________ Date: ____ / ____ / ____

Site Name: ______________________ Site Contact: ______________

Site Address: ______________________

Site Phone and Extension: ______________________ Site Fax: ______________

Please Complete Page 2 of 2 ➔

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PRESCRIBER

PRESCRIBER DECLARATION: I certify that I am prescribing the drug listed above for the patient listed above. I authorize the PROMACTA *CARES* program, operated by the Lash Group, an agent of GlaxoSmithKline, to transmit electronically or otherwise, on my behalf, this prescription to the authorized specialty pharmacy of patient's choice as indicated above. I understand that the dispensing specialty pharmacy shall send the medication to the patient, unless the patient prefers it to be sent to me, in which case I shall deliver it to the patient. I agree that I will not seek reimbursement for any medication provided hereunder from any government program or third-party insurer.

Prescriber Signature (no stamps): ______________________________ SIGN HERE

Name (print): ______________________________ Date: ________ / ________ / ________

The patient, or the patient's authorized representative, MUST sign this form in order to receive reimbursement support and assistance from the GSK PROMACTA *CARES* program. Before signing, you, the patient, should review, understand, and agree to the terms of this authorization and release. If an authorized representative signs for the patient, please indicate relationship to the patient.

PATIENT AUTHORIZATION AND RELEASE TO COLLECT, USE, AND DISCLOSE MEDICAL INFORMATION

I understand that the collection, use, and disclosure of my health information are protected under law. Information contained in this Form, such as my name, address, insurance, prescription, and medical information, is "protected health information." By signing below, I agree to the collection, use, and disclosure of my protected health information as described below.

I understand that my healthcare providers will not condition my medical treatment on my agreement to sign this Patient Authorization and Release.
I understand that once information about me is released based on this authorization, federal privacy laws may not prevent the entities described below from further disclosing my information. However, I understand that such entities have agreed to only use or disclose information it receives for the purposes described in this authorization or as required by law. I understand that this authorization will remain in effect for two (2) years or until my coverage, coding, reimbursement, or other inquiry has been resolved, whichever is longer.

I also understand that I have the right to revoke this authorization at any time by calling 1-877-977-6622 and mailing a signed written statement of my revocation to PO Box 220225, Charlotte, NC 28222-0265, but that such a revocation would end my eligibility to participate in the programs as described. Revoking this authorization will prohibit disclosures after the date written revocation is received, except to the extent that action has been taken in reliance on this authorization. This means that, after you revoke this authorization, your information may be disclosed among GlaxoSmithKline ("GSK") and the company or companies that help GSK administer the programs in order to maintain records of your participation, but it will not be otherwise disclosed or used.

Enrollment in PROMACTA *CARES* (for reimbursement support and assistance)

The patient, or the patient's authorized representative, MUST sign this form in order to receive reimbursement support and assistance from the GSK PROMACTA *CARES* program. Before signing, you, the patient, should review, understand and agree to the terms of this authorization and release. If an authorized representative signs for the patient, please indicate relationship to the patient.

By signing below, I authorize GSK, as well as Lash Group and any other companies that GSK uses to administer PROMACTA *CARES*, to do the following:

1) Request and receive from my doctor, healthcare provider, health insurer, or pharmacist information necessary to investigate and resolve my coverage, coding, or reimbursement inquiry;
2) Collect, use, and disclose to each other any information that I provide to PROMACTA *CARES* for the purpose of investigating and resolving my coverage, coding, or reimbursement inquiry or to administer PROMACTA *CARES*;
3) Disclose to my treating physician, healthcare professional, or pharmacist information I have provided to PROMACTA *CARES* when necessary to resolve my coverage, coding, or reimbursement inquiry. By signing below, I also authorize my insurer, doctor, healthcare provider, and pharmacist to release information about my prescribed medications and medical condition requested by GSK and Lash Group;
4) Market and advertise to me regarding my medical condition, as well as provide me with other general health-related information;
5) Contact my insurer, other potential funding sources, social workers, patient advocacy organizations, patient assistance programs (eg, GSK's Commitment to Access Program), on my behalf in order to determine if I am eligible for health insurance coverage or other funds, and disclose to them information about my prescribed medications and medical condition that has been provided by me or my physician, healthcare provider, or pharmacist; and
6) Disclose any information obtained from the sources listed above to third parties if required by law.

Patient name (print): ______________________ Patient signature: ______________________ SIGN HERE

Date: ________/________/________ Relationship if other than patient: ______________________

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

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

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

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