

Specialty Pharmacy Authorization Form

PROMACTA[®] CARES[™]
(eltrombopag)

This Specialty 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).

Pharmacy Name: _____

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 #: _____

By signing below, you and all pharmacists in your dispensing clinic or 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.