PRESCRIPTION AND SERVICE REQUEST FORM

Please complete form, sign, and fax to **1-844-838-2213**
For questions or assistance, please call Teva Support Solutions℠ Monday–Friday, 9am-7pm EST at **1-844-838-2211**

TEVA SUPPORT SOLUTIONS℠ | CINQAIR® (reslizumab) injection

SERVICES REQUESTED: (Please check all that apply)
❑ Clinical Nurse Educator ❑ Benefits Verification ❑ Patient Financial Assistance ❑ Coding Information

PATIENT INFORMATION (Please type or print clearly)

Name (First, MI, Last, Suffix): Date of Birth: Gender: M ❑ F ❑

Home Address: City: State: ZIP:

❑ Home Phone: ❑ Cell Phone: (please check preferred phone number) Email address:

❑ Check to opt out of receiving voicemails

Drug Allergies:

Current Medications:

INSURANCE INFORMATION (Please complete or provide front and back copies of ALL insurance cards)

Primary Insurance:

Cardholder Name: ID #: Group #: Phone #:

Rx Card Name: ID #: BIN #: PCN #: Group #:

Secondary Insurance:

Cardholder Name: ID #: Group #: Phone #:

Medicare: A ❑ B ❑ C ❑ (Advantage) D ❑

PRESCRIBER INFORMATION

Practice Name:

Prescriber Name: Tax ID:

Practice Mailing Address: City: State: ZIP:

Phone: Fax:

Practice Contact Name: Title:

Phone: Fax:

PRESCRIPTION INFORMATION

CINQAIR 100 mg/10 mL vial
SIG: Infuse 3 mg/kg intravenously every 4 weeks in 50 mL of sterile 0.9% sodium chloride USP for injection over 20-50 minutes

Weight-Based Dosing Calculation: Patient weight in kg X 3 mg = # of mg to infuse every 4 weeks

Patient weight: _____ kg | Infuse: _____ mg every 4 weeks | Dispense: _____ 100 mg vials (100 mg/10 mL) | Refill: _____ times

Patient Diagnosis: ICD-10 Code _____ | Blood Eosinophil Count: _____ cells | Test Date: _____

ADMINISTRATION

Site of Administration: ❑ Prescribing Physician's Office ❑ Non-Prescribing Physician's Office ❑ Hospital Outpatient ❑ Other:

If administration site has a different address than the Prescribing Physician's Practice above, please complete the following:

Name of Preferred Infusion Center:

Contact Name: Phone: Fax: NPI #:

Address: City: State: ZIP:

PATIENT AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

I authorize each of my healthcare provider(s) and my health insurer(s) to use and disclose my protected health information ('PHI') related to: my medical condition and treatment, my health insurance and payment/benefits information, the services provided, and my demographic and contact information to Patient Services and Solutions, Inc. (d/b/a "Teva Support Solutions" and "Shared Solutions Pharmacy" (collectively referred to as the Program)) and its affiliates, agents and representatives, including, but not limited to any third party financial assistance administrators, for the purposes described below.

I understand that the purpose of this Authorization is (i) to enroll me in the Program and contact me by mail, email, text message or by live, autodialed and/or prerecorded messages at the telephone number(s) listed above, or to any future telephone number(s) provided by me (ii) to provide therapy support (iii) to conduct benefits investigation and coordinate my insurance coverage (iv) to coordinate prescription fulfillment and financial assistance; (v) for marketing purposes which includes, but is not limited to, providing me with educational and promotional materials, information, special offers and services related to my therapy or my medical condition which may be funded or sent by a Program affiliate and (vi) for market research purposes which includes contacting me to participate in focus groups, surveys or interviews.

While the Program will safeguard my information and only use it for intended purposes, I understand that once my health information is disclosed it may be re-disclosed by the Program and other recipients and no longer be protected by federal privacy law. This authorization will remain in effect until the Program ends. I understand that I may revoke this authorization at any time, in writing sent to Patient Services and Solutions, Inc., Attn: Privacy Officer, P.O. Box 7588, Overland Park, KS 66207, but that this revocation will only apply to my health care provider(s) and health insurer(s) once they receive notification of my revocation and only to the extent that they have not already taken action based on it. I understand that my refusal to sign this authorization does not impact my right to treatment, payment for treatment, insurance enrollment, eligibility for insurance benefits, as these are not conditioned on me signing this authorization.

➔ **Patient's Signature** Date

If signed by someone other than patient, describe legal authority to do so:

PRESCRIBER SIGNATURE REQUIRED

I authorize Patient Services and Solutions, Inc. to provide any information on this form to the insurer of the named patient and to forward the above prescription, by fax or by other mode of delivery to the pharmacy and site of care chosen by the named patient. If this prescription is being shipped by the pharmacy to my office for administration, I agree to accept the medication on behalf of the above named patient.

➔ **Prescriber's Signature***

Dispense as written **Brand Exchange Permissible** **Date**

NPI #:

*Signature stamps not acceptable. Please attach all prescriptions on Official State Prescription form if mandated by individual state laws