

Dispensing Pharmacy Dose Exchange

Prescription Information and Gilotrif® (afatinib) Enrollment Form

Please complete and fax this form to 1-866-240-4556.

For assistance or additional information, call 1-877-814-3915, Monday–Friday, 8:30 am–6 pm EST.

Patient Information

Patient Name:(First, Last) _____
 Address: _____
 City, State, and Zip: _____
 Home Phone: _____ Cell Phone _____
 Best Time to Contact: _____
 Date of Birth: _____ Gender: _____
 Medication Allergies: _____
 Language Translation (List Language) _____
 Caregiver/Advocate (Name and Phone) _____

Prescriber Information

Prescriber Name: (First, Last) _____
 Practice Name: _____
 Office Contact Name: _____
 Preferred Method of Contact: Phone Fax Email
 Address: _____
 City, State, and Zip: _____
 Email: _____
 Phone: _____ Fax: _____
 NPI# _____ State License# _____
 Tax ID# _____ DEA# _____

Insurance Information

Is the patient insured? YES NO
 Dispensing Pharmacy Name _____
 Policy ID Number: _____
 Bin # _____ PCN# _____ Group# _____
 Pharmacy Plan Name: _____
 Pharmacy Plan Phone Number: _____

Enrollment Authorization

I have received the necessary authorization to release medical and/or other patient information relating to GILOTRIF therapy to Boehringer Ingelheim and its affiliates, agents, representatives, and service providers (including but not limited to United BioSource Corporation, its affiliates, and specialty pharmacies) to use and disclose as necessary to enroll my patient in the Solutions Plus® program. I further authorize Solutions Plus® to forward the prescription below to a pharmacy for fulfillment, and (as applicable) to assess my patient's eligibility for financial assistance. By signing this form, I certify that therapy with Gilotrif® (afatinib) tablets is medically necessary for this patient. I will be supervising the patient's treatment accordingly and I have reviewed the current GILOTRIF prescribing information.

X _____
 Doctor/Prescriber Signature Date

Dose Exchange Prescription (New Strength)

Please complete the dose exchange prescription to the right. Include the new Drug strength and the remaining number of tablets the patient has to be exchanged.

NOTE: In order to qualify for the GILOTRIF Dose Exchange™ your patient must have 9 or more tablets left to exchange.

Gilotrif®(afatinib)tablets

➔ Insert New Strength Here 40 mg Tablet 30 mg Tablet 20 mg Tablet

Directions _____

Number of Tablets remaining to be exchanged _____

X Doctor/Prescriber Signature—Dispense As Written— No Stamp Allowed DATE

X Doctor/Prescriber Signature—Substitution Permitted – No Stamp Allowed DATE

Special/Note: New York Prescribers, please submit prescription on an original NY State prescription blank, your State. For all other States, if not faxed, must be on State specific blank if applicable for your State.

AUTHORIZATION FOR RELEASE OF INFORMATION

- **YOUR MEDICAL TREATMENT, ENROLLMENT OR BENEFITS ARE NOT CONDITIONED ON THIS AUTHORIZATION.**
- **YOU MAY REFUSE TO SIGN THIS AUTHORIZATION FORM, HOWEVER IT MAY PREVENT US FROM COMPLETING A TASK YOU HAVE REQUESTED, SUCH AS THOSE LISTED BELOW.**
- **YOU MAY RECEIVE A COPY OF THIS AUTHORIZATION FORM UPON REQUEST.**

THIS AUTHORIZATION IS VOLUNTARY

TO BE COMPLETED BY PATIENT OR PATIENT REPRESENTATIVE

I, do hereby authorize Accredo Health Group, Inc. to disclose information about me including my demographic information, medical information, prescriptions information, and information contained on this prescription to Boehringer-Ingelheim and its affiliates, agents, representatives, and service providers (including but not limited to United BioSource Corporation and its affiliates and specialty pharmacies, "UBC") (collectively referred to herein as "Recipient"). I understand that the Recipient may also be the discloser of my information. I understand that this authorization is voluntary. I understand that information released under this authorization may be re-disclosed by the Recipient and may no longer be protected by state and federal law.

(Note: The above noted medical records may contain treatment notes regarding radiology, pathology **including HIV test results and genetic testing information**, immunization, procedure(s), **alcohol and drug abuse records protected by Federal Confidentiality Rules 42 CFR Part 2**, and/or other common medical record documentation made by the physician, nurse or other ancillary personnel). I understand that Recipient will access, obtain, use, disclose or receive my health information described above for the purpose of determining my eligibility for and enrollment in plans and programs including, but not limited to, patient assistance, benefits assessments, case management or other programs ("Programs") reasonably related to my condition and treatment. Further, I understand that Recipient will use my information on an ongoing basis to manage and provide ongoing support/services related to these Programs and that communications provided to me by Recipient may be funded in whole or in part by a pharmaceutical manufacturer. I also understand that UBC may receive funding from third parties, such as pharmaceutical manufacturers, in exchange for using or disclosing my information pursuant to this authorization.

I understand that I may withdraw my authorization in writing by contacting Express Scripts, Attn: Privacy Officer, P.O. Box 66982, St. Louis, MO 63166-6982 at any time. Once I withdraw my authorization, the Recipient will discontinue using or disclosing any new information about me. I understand that if I do not withdraw my authorization, this statement will continue to be in effect until my participation in Recipient's plans or programs ceases. I have carefully read and understand the above, and do herein expressly and voluntarily authorize the disclosure of the above information about, or medical records of, my condition to Recipient.

Signature of Patient or Patient's Representative

(Form MUST be completed before signing.)

Relationship to the Patient:

Date

Printed Name of Patient or Patient's Representative _____

* This authorization should be withdrawn as noted above; however, if you would like to opt out of any of the

Programs please contact: Solutions Plus® at 1-877-814-3915.