

Enrollment Form for Tykerb[®] CARES Program (lapatinib)

Please complete the Tykerb[®] CARES Enrollment Form and the patient authorization section. Both the patient and the physician must sign the Enrollment Form. The patient must also sign the authorization section. **Please fax both pages to 1-866-272-9439.** Call 1-866-4-TYKERB (1-866-489-5372) if you have questions.

<u>Patient Information</u>	
Patient Name: _____	
Address: _____ _____	
Phone: (Home) _____ (Work) _____	
(Cell) _____	Date of Birth: _____
Alternate Contact (name/phone): _____	
<u>Insurance</u>	
Primary Rx Insurer: _____	
Phone: _____	
Policy ID #: _____	Group #: _____
Subscriber Name: _____	
Date of Birth: _____	
Secondary Rx Insurer: _____	
Phone: _____	
Policy ID #: _____	Group #: _____
Subscriber Name: _____	
Date of Birth: _____	
<u>Financial Information</u> (Complete only if you want help to determine eligibility for other sources of coverage or assistance)	
Current household income: _____	
Number of family members who rely on that income: _____	

<u>Physician Information</u>	
Physician Name: _____	
Site Name: _____	
Address: _____	
Phone: _____	Fax: _____
Best Time to Call: _____ Preferred Contact: Phone/Fax	
Office Contact Name: _____	
Tax ID #: _____	Payer Specific ID #: _____
NPI #: _____	
<u>Clinical Information</u>	
Diagnosis & ICD-9 Code: _____	
Previous Therapy: _____	

Please note: To enroll in the Tykerb[®] CARES patient adherence program, the patient needs to sign the Enrollment in Tykerb[®] CARES patient adherence program consent section on page 2 of 2.

To receive reimbursement services, the patient needs to sign the Enrollment in Tykerb[®] CARES consent section on page 2 of 2.

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 Enrollment 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 TYKERB to me.

Signature of Patient or Patient Representative:

Name (print): _____

Date: _____
(If signed by representative, explain authority to act for the patient.)

<u>Prescription for TYKERB</u>	
Dosage: _____	Quantity: _____ Refills: _____
State Lic #: _____ DEA #: _____	
Signature: _____ Date: _____	
Dosing Instructions (Sig): _____	
<u>Prescription Fulfillment</u>	
Will TYKERB be dispensed from your facility?	
<input type="checkbox"/> Yes (skip to Physician Declaration) <input type="checkbox"/> No (continue below)	
Specialty Pharmacy	
TYKERB is available from authorized specialty pharmacies through the Tykerb [®] CARES program. Please indicate below how your patient desires to have her prescription filled:	
<input type="checkbox"/> No preference. Please direct prescription to the authorized specialty pharmacy that is in-network for my patient and may result in the lowest cost-sharing for patient. If more than one, one will be selected based on uniformly applied selection criteria.	
<input type="checkbox"/> Please direct prescription to the following authorized specialty pharmacy: _____	
<ul style="list-style-type: none"> • For a complete and up-to-date list of authorized specialty pharmacies, visit www.TykerbCARES.com. • If a lower cost-sharing option is found, healthcare provider and patient will be notified. 	
Where would you like your patient's TYKERB sent?	
<input type="checkbox"/> Directly to my patient at the address listed above.	
<input type="checkbox"/> To my office at the address listed above.	
<input type="checkbox"/> Other address if the address listed above is a post office box: _____ _____	

PHYSICIAN DECLARATION: I certify that I am prescribing the drug listed above for the patient listed above. I authorize the Tykerb[®] 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.

Physician Signature (no stamps): _____

Name (print): _____ **Date:** _____

Please Complete
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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 Enrollment 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 1-866-489-5372 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 Tykerb[®] 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 Tykerb[®] 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 Tykerb[®] 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 Tykerb[®] CARES for the purpose of investigating and resolving my coverage, coding, or reimbursement inquiry or to administer Tykerb[®] CARES;
- 3) Disclose to my treating physician, healthcare professional, or pharmacist information I have provided to Tykerb[®] 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) Contact my insurer, other potential funding sources, social workers, patient advocacy organizations, patient assistance programs (eg, the GSK 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
- 5) Disclose any information obtained from the sources listed above to third parties if required by law.

Patient name (print)

Patient signature

Date

Relationship if other than patient: _____

Enrollment in Tykerb[®] CARES patient adherence program ("adherence program")

The patient, or the patient's authorized representative, MUST sign this form in order to receive GSK's patient adherence program ("adherence program") services. The adherence program is designed to provide you with product information and help you adhere to your medication. 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, I authorize GSK, as well as Lash Group and any other companies that GSK uses to administer the adherence program, to do the following:

- 1) Contact me via telephone (including voicemail) with information about this adherence program, including providing information about TYKERB and information about adherence with my medication and medications in general;
- 2) Collect, use, and disclose any information that I have provided to GSK or any of the companies administering the adherence program for the purpose of providing me with information, contacting me, and otherwise administering such program;
- 3) Market and advertise to me regarding my medical condition, as well as provide me with other general health-related information;
- 4) Contact and disclose information about me to, and receive information about me from, my treating physician, healthcare professional, or pharmacist for purposes of administering this adherence program. By signing below, I also authorize my doctor, healthcare provider, and pharmacist to release information about my prescribed medications and medical condition requested by GSK, as well as Lash Group and any other companies that GSK uses to administer the adherence program;
- 5) Disclose any information obtained from the sources listed above to third parties if required by law; and
- 6) Use such information to review, analyze, improve, and measure the effectiveness of the adherence program.

Patient name (print)

Patient signature

Date

Relationship if other than patient: _____

Tykerb[®] CARES
(lapatinib)