# *Service Request Form for the PodCare+® Patient Support Program*

Complete form, sign, and fax all pages to **1-877-310-8063**.
For assistance with any questions, please call **1-877-999-TOBI (8624)**.

**Attn: New York Prescribers** Please submit prescription on original NY State prescription forms.

## 1 | Complete Patient and Insurance Information

First name Last name Sex ☐ M ☐ F

Date of birth

Patient representative*

Address

City Zip State

Home phone ☐ Preferred OK to leave messages? ☐ Y ☐ N

Cell phone† ☐ Preferred OK to leave messages? ☐ Y ☐ N

Email address†

*For patients under 18 years of age, patient representatives will be enrolled in the program.
†For patients under 18 years of age, please provide patient representative's email and cell phone information.

Patient's known allergies

Primary insurance provider Phone

Beneficiary/cardholder name

ID No. Group No.

Prescription insurance provider Phone

ID No. Group No.

**Please include a copy of both the Prescription and Medical insurance cards (both sides of cards).**

## 2 | Required Patient Signature

### Patient Authorization

I have read and agree to the **Patient Authorization** on page 2.

X

Signature of Patient or Patient Representative‡ (Required)

_____ /_____ /_________

Date of Signature (MM/DD/YYYY)

Relationship to Patient

## 3 | Complete Prescriber Information

First name Last name

Address

City State Zip

NPI No.

Physician tax ID No.

Office contact

Office phone Fax

Email address

## 4 | Complete Rx Information

☐ Dispense as written

☐ Rx: TOBI® Podhaler® (Tobramycin Inhalation Powder) Inhalation of contents of four 28-mg capsules BID for 28 days

☐ Rx: TOBI® (Tobramycin Inhalation Solution, USP) Inhalation of contents of one 300 mg per ampule BID for 28 days

Primary ICD-10 Code (Required):

Secondary ICD-10 Code (Optional):

Dispense # Refills

Preferred Specialty Pharmacy:

Preference will be used, provided it is approved by the patient's insurance plan.

☐ Rx was already sent to a pharmacy

Pharmacy name: ______________________________

Pharmacy phone: ______________________________

## 5 | Physician Consent: Read and Sign

I certify that the above therapy is medically necessary for the previously identified patient and that the information provided is accurate to the best of my knowledge. I am the physician who has prescribed TOBI or TOBI Podhaler to the previously identified patient and that I provided the patient with a description of the PodCare+® Patient Support Program. For the purposes of transmitting this prescription, I authorize **Mylan Specialty L.P.**, and its affiliates, business partners, and agents, to forward as my agent for these limited purposes, this prescription electronically, by facsimile, or by mail to a dispensing pharmacy chosen by the above-named patient.

X

Prescriber Signature (Required)

_____ /_____ /_________

Date of Signature (MM/DD/YYYY)

Please read the following carefully, then sign and date where indicated in section 2.

## Patient Authorization

I give permission for my healthcare providers, my pharmacies, and my health insurer(s) to disclose my personal information, including information about my insurance, prescriptions, medical condition, and health ("Personal Information") to Mylan Specialty L.P. and its affiliates, business partners, and agents (together, the "Mylan Group") so that the Mylan Group can (i) help to verify or coordinate insurance coverage or otherwise obtain payment for my treatment with TOBI® (Tobramycin Inhalation Solution, USP) 300 mg/5 mL or TOBI® Podhaler® (Tobramycin Inhalation Powder) 28 mg per capsule, (ii) coordinate my receipt of, and payment for TOBI or TOBI Podhaler, (iii) facilitate my access to TOBI or TOBI Podhaler, (iv) provide me with educational and promotional information about TOBI or TOBI Podhaler, disease awareness and management programs, and other treatment options, (v) manage the PodCare+® Patient Support Program, (vi) provide me with adherence reminders and support, and (vii) conduct quality assurance, surveys, and other internal business activities in connection with the PodCare+ Patient Support Program.

I give permission to the Mylan Group to disclose my Personal Information to any pharmacies, my health insurer(s), healthcare providers, my representative, and other third parties for the purposes described above. I give permission to the Mylan Group to use my Personal Information for the purposes described above, including to contact me using my contact information on this enrollment form.

I understand that once my Personal Information is disclosed pursuant to this authorization, it may no longer be protected by federal privacy law. I understand that I may refuse to sign this authorization and that such refusal will not affect my treatment or my receipt of health insurance benefits (but would prevent me from participating in the PodCare+ Patient Support Program). I also understand that I may revoke (withdraw) this authorization in the future by mail to: PodCare+ Opt-out Administrator, 1000 Mylan Blvd., Canonsburg, PA 15317, or by fax to 1-877-310-8063, but that will not affect uses and disclosures of my Personal Information previously disclosed in reliance upon this authorization.

I understand that this authorization will remain valid for five (5) years after the date of my signature, unless I revoke it earlier or if applicable state law requires an earlier expiration. I understand that I am entitled to receive a copy of this authorization once I have signed.

‡ If signing as the patient representative, please explain your authority to act on behalf of the patient (eg. legal guardian, parent, power of attorney holder). You may sign as a patient representative if you have the legal authority to act on behalf of the patient. Depending on your state, this may include legal guardians or individuals with medical power of attorney to act on the patient's behalf.

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