Enrollment Form for the 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.

Patient Information

Patient Name: ____________________

Address: ____________________

____

Phone: (Home) __________ (Work) __________

(Cell) __________ Date of Birth: __________

Alternate Contact (name/phone): ____________________

Insurance

Primary Rx Insurer: ____________________

Phone: ____________________

Policy ID #: __________ Group #: __________

Subscriber Name: __________ Date of Birth: __________

Secondary Rx Insurer: ____________________

Phone: ____________________

Policy ID #: __________ Group #: __________

Subscriber Name: __________ Date of Birth: __________

Financial Information (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: __________

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 7.

To receive reimbursement services, the patient needs to sign the **Enrollment in Tykerb® *CARES*** consent section on page 2 of 7.

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 7 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.)

____

Physician Information

Physician Name: ____________________

Site Name: ____________________

Address: ____________________

Phone: __________ Fax: __________

Best Time to Call: __________ Preferred Contact: Phone/Fax

Office Contact Name: ____________________

Tax ID #: __________ Payer Specific ID #: __________

NPI #: ____________________

Clinical Information

Diagnosis & ICD-9 Code: ____________________

Previous Therapy: ____________________

Prescription for TYKERB

Dosage: ______ Quantity: ______ Refills: ______

State Lic #: __________ DEA #: __________

Signature: __________ Date: __________

Dosing Instructions (Sig): ____________________

Prescription Fulfillment

Will TYKERB be dispensed from your facility?

☐ Yes (skip to Physician Declaration) ☐ No (continue below)

Specialty Pharmacy

TYKERB is available from multiple **authorized** specialty pharmacies through the Tykerb® *CARES* program. A complete list of TYKERB **authorized** specialty pharmacies is available at www.tykerbcares.com. Unless patient requests otherwise, the prescription will be directed to the **authorized** specialty pharmacy that provides the lowest cost-sharing for patient. If more than one specialty pharmacy is found, a specialty pharmacy will be selected for patient based on uniformly applied selection criteria.

☐ No preference. Please direct prescription to the authorized specialty pharmacy that provides the lowest cost-sharing option for patient. If more than one specialty pharmacy is found, a specialty pharmacy will be selected based on uniformly applied selection criteria.

☐ Please direct prescription to the following authorized specialty pharmacy providing this specialty pharmacy offers the lowest cost-sharing option for patient:

____

(Note: If a specialty pharmacy is found to offer a lower cost-sharing option for the patient than the specialty pharmacy named above, the prescription will be directed to specialty pharmacy offering the patient the benefit of a lower cost)

Where would you like your patient's TYKERB sent via express delivery?

☐ Directly to my patient at the address listed above.

☐ To my office at the address listed above.

☐ 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 Page 2 of 7 ➔

Please see accompanying full prescribing information, including **BOXED WARNING**.

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, GSK's 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)

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