AUTHORIZATION TO USE OR DISCLOSE

HEALTH INFORMATION

This document authorizes the disclosure and/or use of individually identifiable health information, set forth below, consistent with federal law concerning the privacy of such information.

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize the use or disclosure of my health information as follows:

Persons/organizations authorized to use or disclose the information: My insurer, pharmacist, physician or other health care provider.

Persons/organizations authorized to receive the information: Teva Pharmaceuticals USA, Inc. ("TEVA"), McKesson Specialty ("McKesson") and other companies that TEVA uses to administer the TEVA Assistance Program (the "Program").

Purpose of requested use or disclosure: To (1) confirm my eligibility to receive medications under the Program, (2) facilitate my participation in the Program, and (3) administer the Program.

This Authorization applies to the following information: Information about my prescribed medications and medical condition, including prescriptions.

This Authorization may include disclosure of information relating to **alcohol and drug abuse**, **mental health treatment** (except psychotherapy notes), and **confidential HIV-related information** only if I place my initials on the appropriate line below. I specifically authorize the release of such information to the persons listed above.

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

EXPIRATION

This Authorization expires three (3) years after I cease to participate in the Program.

NOTICE OF RIGHTS AND OTHER INFORMATION

I may refuse to sign this Authorization, but such refusal would cause me to be ineligible to participate in the Program.

I may revoke this Authorization at any time by calling toll-free 877-254-1039 and mailing a written revocation, signed by me or on my behalf, to an address that will be provided by the telephone representative. My revocation will be effective upon receipt, but will not be effective to the extent that the requestor or others have acted in reliance upon this Authorization. Revocation of this Authorization would cause me to be ineligible for further participation in the Program.

I understand that once health information about me has been disclosed in reliance upon this Authorization, the information may no longer be protected by federal privacy laws and may be further disclosed.

I have a right to receive a copy of this Authorization.

_____	_____	_____
Patient signature	***Date***	***Relationship (if other than patient)***

TEVA ASSISTANCE PROGRAM™

If you have any questions regarding the Teva Assistance Program™ please call us toll-free at (877) 254-1039.

ENROLLMENT APPLICATION

FOR INTERNAL USE ONLY

All fields required - FAX completed form to: 1-888-782-6157

SECTION 1: THIS SECTION TO BE COMPLETED BY PATIENT OR LEGAL GUARDIAN

Patient's Name: _____ _____ _____ Date of Birth: _____/_____/_____
First Last M.I. MM DD YYYY

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Social Security #: _____ Gender: ☐ Male ☐ Female

Are you a U.S. Resident? ☐ Yes ☐ No

Household size (Number of persons who contribute to or are dependent on patient's household income): _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employment Status: ☐ Employed ☐ Self-employed ☐ Retired ☐ Unemployed

Total Gross Monthly Household Income: (include all income of persons who contribute to or are dependent on patient's household income)

Salary/Wages: $_____ Unemployment: $_____ Veterans Benefits: $_____

Social Security Retirement: $_____ Alimony/Child Support: $_____ Pension/Retirement: $_____

Supplemental Security Income: $_____ Rental Income: $_____ Other: $_____

Social Security Disability: $_____ Workers Compensation: $_____ TOTAL: $_____

Insurance Information: Indicate if patient has prescription drug benefit for the requested Teva medication through any of the following insurers/payers/programs (Y = yes; N = no)

Insurer/Payer/Program	Rx Benefits (circle)	Insurer/Payer/Program	Rx Benefits (circle)	Insurer/Payer/Program	Rx Benefits (circle)
Medicare	Y N	Medicaid	Y N	Other: _____ List Insurer if "Y"	Y N
Private Insurance: _____ List Insurer if "Y"	Y N	VA Medical Benefits	Y N	None - Uninsured	Check if applicable ☐

I attest that the above information is correct and complete.

Signature of patient or legal guardian: _____ Date: _____

SECTION 2: THIS SECTION TO BE COMPLETED BY ATTENDING PHYSICIAN

Physician's Name: _____ _____
First Last

Physician's Shipping Address (No P.O. Box): _____
Medication will be delivered to this address.

City: _____ State: _____ Zip Code: _____

Phone #: _____ FAX #: _____

State License #: _____ NPI #: _____

Medication requested for the above patient:

- ☐ ADRUCIL® (Fluorouracil Injection, USP)
- ☐ Bleomycin for Injection, USP
- ☐ Carboplatin for Injection, USP
- ☐ Carboplatin Lyophilized Powder for Injection
- ☐ Cyclosporine Capsules Modified, Cyclosporine Oral Solution Modified
- ☐ Dacarbazine for Injection, USP
- ☐ Daunorubicin HCl Injection
- ☐ Epirubicin HCl Injection
- ☐ Fludarabine Phosphate for Injection, USP (Lyophilized)
- ☐ GALZIN® Capsules (zinc acetate)
- ☐ Idarubicin HCl Injection
- ☐ Ifosfamide Injection/Mesna Injection Kit
- ☐ Irinotecan Injection
- ☐ Leuprolide Acetate Injection
- ☐ Mesna Injection
- ☐ ORAP® Tablets (pimozide)
- ☐ Paclitaxel Injection
- ☐ Pamidronate Disodium Injection
- ☐ ProAir® HFA (albuterol sulfate aerosol HFA)
- ☐ Proglycem® (diazoxide, USP) Oral Suspension
- ☐ PURINETHOL® (mercaptopurine) Tablets**
- ☐ QVAR® (Beclomethasone Dipropionate HFA)
- ☐ TOPOSAR® (Etoposide Injection, USP)
- ☐ VINCASAR PFS® (Vincristine Sulfate Injection, USP)
- ☐ Vinorelbine Tartrate Injection
- ☐ Vivactil® (Protripyline HCl) Tablets
- ☐ ZANOSAR® (Streptozocin Sterile Powder)

** Existing PAP patients only; not accepting new Purinethol® enrollments effective July 2006

I have no knowledge of any intent to sell, barter or give this product to any person other than the patient for whom it has been prescribed. I attest to the best of my knowledge that the information above is correct and the intended therapy is medically necessary for the patient listed above.

Signature of physician: _____ Date: _____

TO ENROLL, PLEASE COMPLETE THIS APPLICATION.

Applications must be accompanied by a signed Patient Authorized Release Disclosure of Medical Information Form. Upon Successful Enrollment, physician will receive a faxed approval letter with instructions on how to order product for their patient.

The eligibility requirements for acceptance into the TEVA Assistance Program are subject to change at any time, with or without prior notice. The Program reserves the right to disqualify any patient's participation in the Program if, in the sole discretion of the Program, that patient fails to meet the eligibility requirements then in effect.