

ADULT PRESCRIPTION AND SERVICE REQUEST FORM

SIMLANDI® (adalimumab-ryvk) injection

ENROLLMENT FORM

 PLEASE FAX COMPLETED FORM TO **866-676-4073**
 FOR QUESTIONS, CALL **888-587-3263**
teva | Shared Solutions® for Biosimilars

Patient

Requested Services:
 Benefits Verification
 Prior Authorization Support
 Commercial Copay Program
 Appeals Support
 Injection Training

1 PATIENT INFORMATION (PATIENT TO COMPLETE SECTIONS 1-3)			
Patient Name (First MI Last):			
DOB (mm/dd/yyyy):		Phone:	
Address:			
City:		State:	ZIP:
Contact Name (if other than patient):		Contact Phone:	
Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unspecified	


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2 INSURANCE INFORMATION			
PLEASE INCLUDE COPIES OF INSURANCE CARDS, FRONT AND BACK			
<input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> VA <input type="checkbox"/> Other government-sponsored plan			
Cardholder Name:		Rx Insurance Name:	
Medical Insurance Name:		Rx ID #:	Rx Group #:
Medical Insurance ID #:	Group #:	Rx BIN #:	Rx PCN #:

3 PATIENT OR PERSONAL REPRESENTATIVE SIGNATURE(S)	
PATIENT AUTHORIZATION	
<p>I authorize my healthcare providers, pharmacies, and health plan(s) to disclose my personal health information on this form as well as information related to my medical condition, treatment, care management, prescriptions, and health insurance to Teva Pharmaceuticals, Inc. and its affiliates, contractors and agents, including their third party patient support program service provider (collectively "Teva") for the purposes described below.</p> <p>I understand that the purpose of this Authorization is to provide me with access to services related to my prescribed medication and/or medical condition ("Program"), including (i) enrollment in the Program; (ii) conducting benefits investigation and coordinating my insurance coverage, which may include allowing a Teva field based representative to access my information and engage with my healthcare provider directly, if necessary; (iii) if needed, determining my eligibility for and coordinating financial assistance; (iv) coordinating prescription fulfillment and product replacement; (v) providing nursing support; (vi) facilitating quality and adverse event reporting activities; (vii) conducting data analytics, market research, and Program related business activities; (viii) contacting me by direct mail or by electronic or telephonic means to the contact information on this form or to any future contact information provided by me or on my behalf in connection with carrying out the Program services, including adherence related communications, reminders, and support, for which the third party service provider may receive financial remuneration from the manufacturer of your medication.</p> <p>I understand that I may cancel this Authorization at any time, by writing to Teva, Attn: Authorizations, P.O. Box 7613, Overland Park, KS 66207, but my cancellation will not apply to any information already disclosed pursuant to this Authorization. This Authorization will remain in effect until the Program ends. I understand that once my information is disclosed, it may be subject to redisclosure by the recipients and no longer protected by federal privacy law. I understand that my treatment, payment for treatment, insurance enrollment, or eligibility for insurance benefits will not be directly affected if I do not sign this Authorization. However, if I do not sign this Authorization, I may not be able to receive Program services. I am also entitled to a copy of this signed Authorization.</p>	
Patient Signature: ✗	Date: ✗
If signed by someone other than the patient, describe legal authority to do so:	


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Healthcare Professional

1 PHYSICIAN INFORMATION (PHYSICIAN TO COMPLETE SECTIONS 1-3)			
Physician Name:		NPI #:	
Address:		Group Tax ID #:	
City:	State:	ZIP:	
Office Contact Name:		Contact Title:	
Contact Phone:		Contact Fax:	



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2 PRESCRIPTION INFORMATION	
Patient Name (First MI Last):	DOB (mm/dd/yyyy):
<input type="checkbox"/> New <input type="checkbox"/> Switch <input type="checkbox"/> Restart	
DIAGNOSIS <input type="checkbox"/> Rheumatoid Arthritis (RA) <input type="checkbox"/> Psoriatic Arthritis (PsA) <input type="checkbox"/> Ankylosing Spondylitis (AS) <input type="checkbox"/> Crohn's Disease (CD) <input type="checkbox"/> Ulcerative Colitis (UC) <input type="checkbox"/> Plaque Psoriasis (Ps) <input type="checkbox"/> Uveitis <input type="checkbox"/> Hidradenitis Suppurativa (HS)	
PHARMACY PRESCRIPTION Please select the medication, and complete and sign the corresponding pharmacy prescription	
Patient's preferred Specialty Pharmacy* _____ Number of refills _____ <input type="checkbox"/> Do not send to Specialty Pharmacy	
<small>*Prescription will be triaged to preferred pharmacy unless otherwise dictated by insurance mandate and/or patient preference.</small>	

RHEUMATOID ARTHRITIS	CROHN'S DISEASE or ULCERATIVE COLITIS
Select Recommended Dose SIMLANDI Autoinjector 40 mg/0.4 mL <input type="checkbox"/> 40 mg SC every other week <input type="checkbox"/> 40 mg SC every week [†] <input type="checkbox"/> 80 mg SC every other week [†] <small>[†]For patients not receiving methotrexate</small>	Select Recommended Dose(s) SIMLANDI Autoinjector 40 mg/0.4 mL <input type="checkbox"/> Initial dose: 160 mg SC on Day 1 (given in one day or split over two consecutive days), followed by 80 mg SC on Day 15 <input type="checkbox"/> Maintenance dose: 40 mg SC every other week starting on Day 29

PLAQUE PSORIASIS or UVEITIS
Select Recommended Dose(s) SIMLANDI Autoinjector 40 mg/0.4 mL <input type="checkbox"/> Initial dose: 80 mg SC <input type="checkbox"/> Maintenance dose: 40 mg SC every other week starting one week after initial 80 mg SC dose

PSORIATIC ARTHRITIS or ANKYLOSING SPONDYLITIS	HIDRADENITIS SUPPURATIVA
Select Recommended Dose SIMLANDI Autoinjector 40 mg/0.4 mL <input type="checkbox"/> 40 mg SC every other week	Select Recommended Dose(s) SIMLANDI Autoinjector 40 mg/0.4 mL <input type="checkbox"/> Initial dose: 160 mg SC on Day 1 (given in one day or split over two consecutive days), followed by 80 mg SC on Day 15 <input type="checkbox"/> Maintenance dose: 40 mg SC every week starting on Day 29 <input type="checkbox"/> 80 mg SC every other week starting on Day 29

3 PRESCRIBER SIGNATURE
<p>After discussing the Program for my prescribed medication and/or medical condition (including its agents, service providers, and dispensing pharmacies) with the patient, the patient has elected to participate in the Program. I authorize the release of medical and/or other patient information relating to therapy to this Program, Teva Pharmaceuticals, Inc., its affiliates and its designated agents and service providers (collectively, "Teva"), to use and disclose as needed for fulfillment of the prescription related to this Program, and furnish any information in this form to the insurer of the above-named patient. I understand that Teva reserves the right to modify or terminate this Program at any time for any reason without any prior notice. I understand that I am under no obligation to prescribe a specific drug and I have not received, nor will I receive any benefit, for prescribing a specific drug. I certify that I have a signed copy on file of my patient's current and completed Patient Authorization so that I may share this patient's health information with Teva.</p> <p>**STAMP SIGNATURE NOT PERMITTED – INK SIGNATURE ONLY. Please attach all prescriptions on Official State Prescription form if mandated by individual state laws**</p> <p>The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, or hard copy prescription, etc.</p>
Prescriber Signature: X
Date: X

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