Solutions Plus
Patient support. Our priority.™

Prescription Information and Gilotrif® (afatinib) Enrollment Form

Please complete and fax this form to 1-866-240-4556.
For assistance or additional information, call 1-877-814-3915, Monday–Friday, 8 am–8 pm EST.

Patient Information

Patient Name:(First, Last) _____
Address: _____
City, State, and Zip: _____
Home Phone: _____ Cell Phone _____
Best Time to Contact: _____
Date of Birth: _____ Gender: _____
Medication Allergies: _____
Language Translation (List Language) _____
Caregiver/Advocate (Name and Phone) _____
Reimbursement Services Only ☐ YES
Commercial Copay Support Only ☐ YES

Prescriber Information

Prescriber Name: (First, Last) _____
Practice Name: _____
Office Contact Name: _____
Preferred Method of Contact: ☐ Phone ☐ Fax ☐ Email
Address: _____
City, State, and Zip: _____
Email: _____
Phone: _____ Fax: _____
NPI# _____ State License# _____
Tax ID# _____

Insurance Information

Is the patient insured? ☐ YES ☐ NO
Policy Holder Name: _____
Policy ID Number: _____
Bin # _____ PCN# _____ Group# _____
Pharmacy Plan Name: _____
Pharmacy Plan Phone Number: _____
Accredo Specialty Pharmacy or Dispensing Pharmacy _____
Please provide a copy of the front and back of the insurance cards

Diagnosis and Clinical Information

Diagnosis:

☐ C34.10 ☐ C34.11 ☐ C34.12 ☐ C34.2
☐ C34.30 ☐ C34.31 ☐ C34.32 ☐ C34.80
☐ C34.81 ☐ C34.82 ☐ C34.90 ☐ C34.91
☐ C34.92 ☐ Other ICD-10

The patient has tested positive for EGFR mutation ☐ YES ☐ NO
The patient has squamous histology ☐ YES ☐ NO
Nurse Support Introduction ☐ YES ☐ NO

Enrollment Authorization

☐ Check to request benefits investigation only. If checked, please sign below and leave Rx information blank.

I have received the necessary authorization to release medical and/or other patient information relating to GILOTRIF therapy to Boehringer Ingelheim and its affiliates, agents, representatives, and service providers (including but not limited to United BioSource Corporation, its affiliates, and specialty pharmacies) to use and disclose as necessary to enroll my patient in the Solutions Plus® program. I further authorize Solutions Plus® to forward the prescription below to a pharmacy for fulfillment, and (as applicable) to assess my patient's eligibility for financial assistance. By signing this form, I certify that therapy with Gilotrif® (afatinib) tablets is medically necessary for this patient. I will be supervising the patient's treatment accordingly and I have reviewed the current GILOTRIF prescribing information.

X _____

Prescription Information for Newly Prescribed Patients Only – Please only use for FIRST GILOTRIF Prescription

Gilotrif® (afatinib) tablets ☐ 40 mg Tablet ☐ 30 mg Tablet ☐ 20 mg Tablet
Directions _____

Quantity _____ Day Supply _____ Refills _____

X _____ Doctor/Prescriber Signature—Dispense as Written – No Stamp Allowed Date

X _____ Doctor/Prescriber Signature—Substitution Permitted – No Stamp Allowed Date

Dose Exchange Prescription (New Strength)

Please indicate the number of tablets the patient has remaining and complete both sections below.

Gilotrif® (afatinib) tablets
→ Insert New Strength Here ☐ 40 mg Tablet ☐ 30 mg Tablet ☐ 20 mg Tablet

Directions _____

Number of Tablets remaining to be exchanged _____

X Doctor/Prescriber Signature—Dispense as Written – No Stamp Allowed Date

X Doctor/Prescriber Signature— Substitution Permitted– No Stamp Allowed Date

Dose Exchange Prescription (Ongoing Refills)

You must indicate the strength for the next full prescription before either dose can be sent.

Gilotrif® (afatinib) tablets
→ Insert New Strength Here ☐ 40 mg Tablet ☐ 30 mg Tablet ☐ 20 mg Tablet

Directions _____

Quantity 30 Day Supply 30 Refills _____

X Doctor/Prescriber Signature—Dispense as Written – No Stamp Allowed Date

X Doctor/Prescriber Signature— Substitution Permitted– No Stamp Allowed Date

Special Note: The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

AUTHORIZATION FOR RELEASE OF INFORMATION

- YOUR MEDICAL TREATMENT, ENROLLMENT OR BENEFITS CANNOT BE CONDITIONED ON THIS AUTHORIZATION.
- YOU MAY REFUSE TO SIGN THIS AUTHORIZATION FORM, HOWEVER IT MAY PREVENT US FROM COMPLETING A TASK YOU HAVE REQUESTED, SUCH AS THOSE LISTED BELOW.
- YOU MAY RECEIVE A COPY OF THIS AUTHORIZATION FORM UPON REQUEST.

THIS AUTHORIZATION IS VOLUNTARY

TO BE COMPLETED BY PATIENT OR PATIENT REPRESENTATIVE

I, do hereby authorize Accredo Health Group, Inc. to disclose information about me including my demographic information, medical information, prescriptions information, and information contained on this prescription to Boehringer-Ingelheim and its affiliates, agents, representatives, and service providers (including but not limited to United BioSource Corporation and its affiliates and specialty pharmacies) (collectively referred to herein as "Recipient"). I understand that the Recipient may also be the discloser of my information. I understand that this authorization is voluntary. I understand that information released under this authorization may be re-disclosed by the Recipient and may no longer be protected by state and federal law.

(Note: The above noted medical records may contain treatment notes regarding radiology, pathology ***including HIV test results***, immunization, procedure(s), ***protected by Federal Confidentiality Rules 42 CFR Part 2***, and/or other common medical record documentation made by the physician, nurse or other ancillary personnel). I understand that Recipient will access, obtain, use, disclose or receive my health information described above for the purpose of determining my eligibility for and enrollment in plans and programs including, but not limited to, Patient Assistance, benefits assessments, case management or other programs ("Programs") reasonably related to my condition and treatment. Further, I understand that Recipient will use my information on an ongoing basis to manage and provide ongoing support/services related to these Programs and that communications provided to me by Recipient may be funded in whole or in part by a pharmaceutical manufacturer. I also understand that Recipient may receive funding from third parties, such as pharmaceutical manufacturers, in exchange for using or disclosing my information pursuant to this authorization.

I understand that I may withdraw my authorization in writing by contacting Express Scripts, Attn: Privacy Officer, P.O. Box 66982, St. Louis, MO 63166-6982 at any time, except to the extent that action has been taken in reliance on this statement. I understand that if I do not withdraw my authorization, this statement will continue to be in effect until my participation in Recipient's plans or programs ceases. I have carefully read and understand the above, and do herein expressly and voluntarily authorize the disclosure of the above information about, or medical records of, my condition to Recipient.

_____ _____

Signature of Patient or Patient's Representative Date

(Form MUST be completed before signing.)

Relationship to the Patient:

Printed Name of Patient or Patient's Representative_____

* This authorization should be withdrawn as noted above; however, if you would like to opt out of any of the Programs please contact: Solutions Plus® at 1-877-814-3915.