



## 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)*



# ENROLLMENT APPLICATION

FOR INTERNAL USE ONLY

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

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: M  F

Are you a U.S. Resident?  Yes  No Household size (number of persons who contribute to or are dependent on patient's household income): \_\_\_\_\_

### 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 insurance 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 _____ <small>List Insurer of "Y"</small>	Y N
Private Insurance _____ <small>List Insurer of "Y"</small>	Y N	VA Medical Benefits	Y N	None - Uninsured	Check if applicable <input type="checkbox"/>

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:

- Cyclosporine Capsules Modified, Cyclosporine Oral Solution Modified
- GALZIN® (zinc acetate) Capsules
- ORAP® (pimozide) Tablets
- ProAir® HFA (albuterol sulfate) Inhalation Aerosol
- Proglycem® (diazoxide, USP) Oral Suspension
- PURINETHOL® (mercaptopurine) Tablets\*\*
- QVAR® (beclomethasone dipropionate HFA)
- Vivactil® (protriptyline HCl) Tablets, USP

\*\* 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.

Application 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.