A Guide to the Prescription and Service Request Form

Complete a Prescription and Service Request Form for each new patient and fax it to Teva Support Solutions® at 1-844-838-2213.

SERVICES REQUESTED
To initiate the full benefits offered by Teva Support Solutions®, check all the appropriate services.

PREFERRED ACQUISITION METHOD
This section should only be completed if CINQAIR® (reslizumab) Injection will be administered within the physician's office setting. Indicate the preferred method of product acquisition.

PATIENT INFORMATION
Patients will be contacted regarding their insurance coverage, financial assistance, and will receive ongoing nursing support and education.

INSURANCE INFORMATION
A Nurse Case Administrator will be assigned to verify benefits, p[illegible] informa[illegible] about Prior Authorization and will be available to answer any qu[illegible]ions.

PRESCRIPTION INFORMATION
Record patient weight in kilograms and verify weight-based dosing calculation. Be sure to include Blood Eosinophil Count and test date.

ADMINISTRATION
Submit complete information about the site of administration if the patient will not receive the medication at the Prescribing Physician's Office.

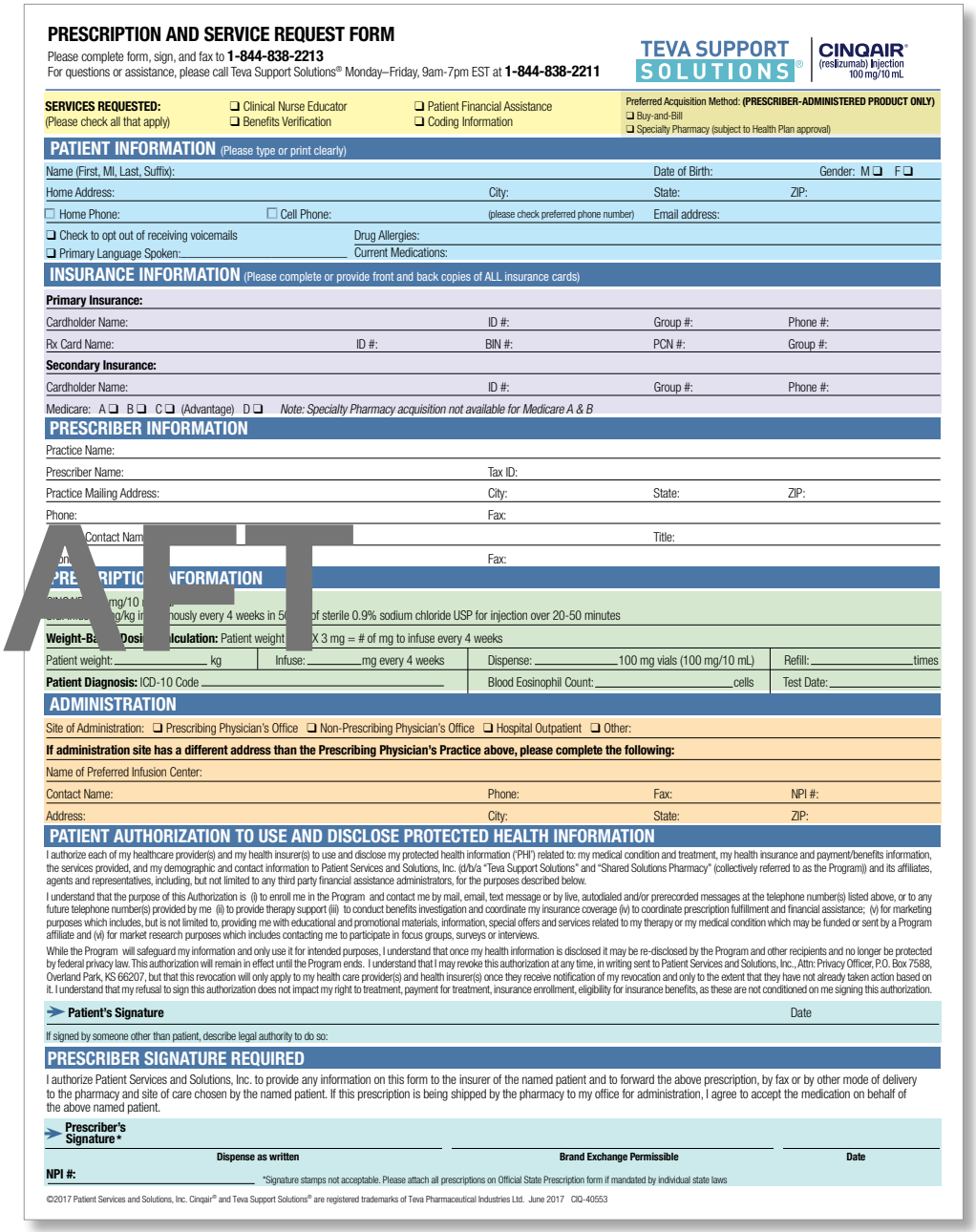
PATIENT and PROVIDER AUTHORIZATION
Be sure to include valid patient and prescriber signatures and date. Prescriber must include NPI number.

Important Safety Information

WARNING: ANAPHYLAXIS

- **Anaphylaxis has been observed with CINQAIR (reslizumab) infusion in 0.3% of patients in placebo-controlled clinical studies. Anaphylaxis was reported as early as the second dose of CINQAIR.**
- **Anaphylaxis can be life-threatening. Patients should be observed for an appropriate period of time after CINQAIR administration by a healthcare professional prepared to manage anaphylaxis. Discontinue CINQAIR immediately if the patient experiences signs or symptoms of anaphylaxis.**

Please see additional Important Safety Information on back and enclosed full Prescribing Information, including Boxed WARNING for CINQAIR® (reslizumab) Injection.



PRESCRIPTION AND SERVICE REQUEST FORM

Please complete form, sign, and fax to **1-844-838-2213**
For questions or assistance, please call Teva Support Solutions® Monday–Friday, 9am-7pm EST at **1-844-838-2211**

TEVA SUPPORT SOLUTIONS® | CINQAIR® (reslizumab) Injection 100 mg/10 mL

SERVICES REQUESTED: (Please check all that apply)
❑ Clinical Nurse Educator ❑ Benefits Verification ❑ Patient Financial Assistance ❑ Coding Information

Preferred Acquisition Method: **(PRESCRIBER-ADMINISTERED PRODUCT ONLY)**
❑ Buy-and-Bill
❑ Specialty Pharmacy (subject to Health Plan approval)

PATIENT INFORMATION (Please type or print clearly)
Name (First, MI, Last, Suffix): | Date of Birth: | Gender: M ❑ F ❑
Home Address: | City: | State: | ZIP:
☐ Home Phone: ☐ Cell Phone: (please check preferred phone number) | Email address:
❑ Check to opt out of receiving voicemails | Drug Allergies:
❑ Primary Language Spoken: | Current Medications:

INSURANCE INFORMATION (Please complete or provide front and back copies of ALL insurance cards)
Primary Insurance:
Cardholder Name: | ID #: | Group #: | Phone #:
Rx Card Name: | ID #: | BIN #: | PCN #: | Group #:
Secondary Insurance:
Cardholder Name: | ID #: | Group #: | Phone #:
Medicare: A ❑ B ❑ C ❑ (Advantage) D ❑ *Note: Specialty Pharmacy acquisition not available for Medicare A & B*

PRESCRIBER INFORMATION
Practice Name:
Prescriber Name: | Tax ID:
Practice Mailing Address: | City: | State: | ZIP:
Phone: | Fax:
Contact Nam[illegible] | Title:
[illegible] | Fax:

PRE[illegible]RIPTI[illegible]NFORMATION
[illegible]mg/10 [illegible]
[illegible]g/kg i[illegible]nously every 4 weeks in 5[illegible] of sterile 0.9% sodium chloride USP for injection over 20-50 minutes
Weight-Ba[illegible] Dosi[illegible]lculation: Patient weight [illegible] X 3 mg = # of mg to infuse every 4 weeks
Patient weight: _____ kg | Infuse: _____ mg every 4 weeks | Dispense: _____ 100 mg vials (100 mg/10 mL) | Refill: _____ times
Patient Diagnosis: ICD-10 Code _____ | Blood Eosinophil Count: _____ cells | Test Date: _____

ADMINISTRATION
Site of Administration: ❑ Prescribing Physician's Office ❑ Non-Prescribing Physician's Office ❑ Hospital Outpatient ❑ Other:
If administration site has a different address than the Prescribing Physician's Practice above, please complete the following:
Name of Preferred Infusion Center:
Contact Name: | Phone: | Fax: | NPI #:
Address: | City: | State: | ZIP:

PATIENT AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION
I authorize each of my healthcare provider(s) and my health insurer(s) to use and disclose my protected health information ("PHI") related to: my medical condition and treatment, my health insurance and payment/benefits information, the services provided, and my demographic and contact information to Patient Services and Solutions, Inc. (d/b/a "Teva Support Solutions" and "Shared Solutions Pharmacy" (collectively referred to as the Program)) and its affiliates, agents and representatives, including, but not limited to any third party financial assistance administrators, for the purposes described below.

I understand that the purpose of this Authorization is (i) to enroll me in the Program and contact me by mail, email, text message or by live, autodialed and/or prerecorded messages at the telephone number(s) listed above, or to any future telephone number(s) provided by me (ii) to provide therapy support (iii) to conduct benefits investigation and coordinate my insurance coverage (iv) to coordinate prescription fulfillment and financial assistance; (v) for marketing purposes which includes, but is not limited to, providing me with educational and promotional materials, information, special offers and services related to my therapy or my medical condition which may be funded or sent by a Program affiliate and (vi) for market research purposes which includes contacting me to participate in focus groups, surveys or interviews.

While the Program will safeguard my information and only use it for intended purposes, I understand that once my health information is disclosed it may be re-disclosed by the Program and other recipients and no longer be protected by federal privacy law. This authorization will remain in effect until the Program ends. I understand that I may revoke this authorization at any time, in writing sent to Patient Services and Solutions, Inc., Attn: Privacy Officer, P.O. Box 7588, Overland Park, KS 66207, but that this revocation will only apply to my health care provider(s) and health insurer(s) once they receive notification of my revocation and only to the extent that they have not already taken action based on it. I understand that my refusal to sign this authorization does not impact my right to treatment, payment for treatment, insurance enrollment, eligibility for insurance benefits, as these are not conditioned on me signing this authorization.

Patient's Signature | Date
If signed by someone other than patient, describe legal authority to do so:

PRESCRIBER SIGNATURE REQUIRED
I authorize Patient Services and Solutions, Inc. to provide any information on this form to the insurer of the named patient and to forward the above prescription, by fax or by other mode of delivery to the pharmacy and site of care chosen by the named patient. If this prescription is being shipped by the pharmacy to my office for administration, I agree to accept the medication on behalf of the above named patient.

Prescriber's Signature* | **Dispense as written** | **Brand Exchange Permissible** | **Date**
NPI #: *Signature stamps not acceptable. Please attach all prescriptions on Official State Prescription form if mandated by individual state laws

TEVA SUPPORT SOLUTIONS®
1-844-838-2211
Monday–Friday, 9AM–7PM ET
www.TevaSupportSolutions.com

CINQAIR® (reslizumab) Injection

Indications and Usage

CINQAIR (reslizumab) Injection is an interleukin-5 antagonist monoclonal antibody (IgG4 kappa) indicated for add-on maintenance treatment of patients with severe asthma aged 18 years and older, and with an eosinophilic phenotype.

Limitations of Use: CINQAIR is **not** indicated for:
- treatment of other eosinophilic conditions
- relief of acute bronchospasm or status asthmaticus

Important Safety Information

WARNING: ANAPHYLAXIS

- **Anaphylaxis has been observed with CINQAIR (reslizumab) infusion in 0.3% of patients in placebo-controlled clinical studies. Anaphylaxis was reported as early as the second dose of CINQAIR.**
- **Anaphylaxis can be life-threatening. Patients should be observed for an appropriate period of time after CINQAIR administration by a healthcare professional prepared to manage anaphylaxis. Discontinue CINQAIR immediately if the patient experiences signs or symptoms of anaphylaxis.**

CONTRAINDICATIONS

- CINQAIR is contraindicated in patients who have known hypersensitivity to reslizumab or any of its excipients.

WARNINGS AND PRECAUTIONS

- **Acute Asthma Symptoms or Deteriorating Disease:** CINQAIR should not be used to treat acute asthma symptoms or acute exacerbations. Do not use CINQAIR to treat acute bronchospasm or status asthmaticus. Patients should seek medical advice if their asthma remains uncontrolled or worsens after initiation of treatment with CINQAIR.
- **Malignancy:** In placebo-controlled clinical studies, 6/1028 (0.6%) patients receiving 3 mg/kg CINQAIR had at least 1 malignant neoplasm reported compared to 2/730 (0.3%) patients in the placebo group. The observed malignancies in CINQAIR-treated patients were diverse in nature and without clustering of any particular tissue type. The majority of malignancies were diagnosed within less than six months of exposure to CINQAIR.
- **Reduction of Corticosteroid Dosage:** No clinical studies have been conducted to assess reduction of maintenance corticosteroid dosages following administration of CINQAIR. Do not discontinue systemic or inhaled corticosteroids abruptly upon initiation of therapy with CINQAIR. Reductions in corticosteroid dose, if appropriate, should be gradual and performed under the supervision of a physician. Reduction in corticosteroid dose may be associated with systemic withdrawal symptoms and/or unmask conditions previously suppressed by systemic corticosteroid therapy.
- **Parasitic (Helminth) Infection:** Eosinophils may be involved in the immunological response to some helminth infections. Treat patients with pre-existing helminth infections before initiating CINQAIR. If patients become infected while receiving treatment with CINQAIR and do not respond to anti-helminth treatment, discontinue treatment with CINQAIR until infection resolves.

ADVERSE REACTIONS

- Adverse reactions that occurred at ≥2% incidence and more commonly than in the placebo group included 1 event: oropharyngeal pain (2.6% vs. 2.2%).
- Elevated baseline creatine phosphokinase (CPK) was more frequent in patients randomized to CINQAIR (14%) versus placebo (9%). Transient CPK elevations in patients with normal baseline CPK values were observed more frequently with CINQAIR (20%) versus placebo (18%) during routine laboratory assessments.
- Myalgia was reported in 1% (10/1028) of patients in the CINQAIR 3 mg/kg group compared to 0.5% (4/730) of patients in the placebo group.
- Immunogenicity: In placebo-controlled studies, a treatment-emergent anti-reslizumab antibody response developed in 53/983 (5.4%) of CINQAIR-treated patients (3 mg/kg). The antibody responses were of low titer and often transient. There was no detectable impact of the antibodies on the clinical pharmacokinetics, pharmacodynamics, clinical efficacy, and safety of CINQAIR.

CINQAIR® (reslizumab) Injection 100 mg/10 mL | TEVA SUPPORT SOLUTIONS®

Please see enclosed full Prescribing Information, including Boxed WARNING for CINQAIR®.