ENROLLMENT FORM PLEASE FAX COMPLETED FORM TO 866-676-4073 FOR QUESTIONS, CALL **888-587-3263**

teva | **Shared Solutions**® for Biosimilars

Address: City:							
Address: City:	1 PATIENT	INFORMATION (PATI	ENT TO COM	APLETE SECTIONS	1-3)		
Address: City: State: ZIP: Contact Name (if other than patient): Contact Phone: Permanent U.S. Resident?: Yes No Preferred Language: English Spanish Other Gender: Male Female Unspecified 2	First Name (First MI Last):	:					
Contact Name (if other than patient): Contact Name (if other than patient):	DOB (mm/dd/yyyy):			Phone:			
Contact Name (if other than patient): Contact Phone: Permanent U.S. Resident??: Ves No Preferred Language: English Spanish Other Gender: Male Female Unspecified 2	Address:						
Permanent U.S. Resident?: Ves No Preferred Language: English Spanish Other Gender: Male Female Unspecified 2	City:			State:			ZIP:
PLEASE INCLUDE COPY OF INSURANCE CARDS, FRONT AND BACK AND ENLARGED Medicare Coverage: Part A Part B Part D Medicare Advantage Medicare Policy #: Effective Date: If PART D or Medicare Advantage, list Prescription Drug Plan information below: Insurance Name Phone ID/Policy # Group # Primary Secondary State Program Weteran or Other Plan Personal Pending Veteran Yes No Applied for VA? Yes No Any other government sponsored plan? Yes No Any other government sponsore	Contact Name (if other tha	an patient):		Contact Phone:			
PLEASE INCLUDE COPY OF INSURANCE CARDS, FRONT AND BACK AND ENLARGED Medicare Coverage: Part A Part B Part D Medicare Advantage Medicare Policy #: Effective Date: If PART D or Medicare Advantage, list Prescription Drug Plan information below:	Permanent U.S. Resident?: [☐ Yes ☐ No ☐ Preferred Lan	guage: 🗌 Eng	glish 🗌 Spanish 🔲 C	ther Geno	er: 🗌 Male	☐ Female ☐ Unspecified
Medicare Coverage: Part A Part B Part D Medicare Advantage Medicare Policy #: Effective Date: If PART D or Medicare Advantage, list Prescription Drug Plan information below: Insurance Name Phone ID/Policy # Group # Primary Secondary Secondary Veteran or Other Plan Veteran Yes No Applied for VA? Yes No Any other government sponsored plan? Yes No Any other government sponsored plan? Yes No Applied for VA? Yes No Any other government sponsored plan? Yes No Applied for VA? Yes No Any other government sponsored plan? Yes No Applied for VA? Yes No Appl	2 INSURA	NCE INFORMATION					
Insurance Name		**PLEASE INCLUDE COPY OF	F INSURANCE	CARDS, FRONT AND	BACK AND ENL	ARGED**	
Insurance Name Phone ID/Policy # Group # Primary Secondary State Program Weteran or Other Plan Medicaid Not applied Denied Pending Veteran Yes No Applied for VA? Yes No Any other government sponsored plan? Yes No Any other government sponsored plan? Yes No Applied for VA? Yes No Applied for	Medicare Coverage: 🗌 Par	rt A 🗌 Part B 🗌 Part D 🗌	Medicare Ad	vantage Medicare	e Policy #:	E	ffective Date:
Primary Secondary State Program Veteran or Other Plan Medicaid Not applied Denied Pending Veteran Yes No Applied for VA? Yes No Any other government sponsored plan? Yes No Any other government sponsored plan? Yes No PATIENT AUTHORIZATION authorize my healthcare providers, pharmacies, and health plan(s) to disclose my personal health information on this form as well as information elated to my medical condition, treatment, care management, prescriptions, and health insurance to Teva Pharmaceuticals USA, Inc. and its affiliates, contractors and agents, including their third party patient support program service provider (collectively "Teva") for the purposes described below. 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) freeded, 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 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. understand that I may cancel this Authorization at any time, by writing to Teva, Attn: Authorization. This Authorization from the manufacturer of your medication. understand tha	If PART D or Medicare Adv	vantage, list Prescription Dru	ıg Plan infor	mation below:			
State Program Veteran or Other Plan		Insurance Name	П	Phone	ID/F	olicy#	Group #
State Program Weteran or Other Plan	Primary						
Medicaid Not applied Denied Pending Veteran Yes No Applied for VA? Yes No Any other government sponsored plan? Yes No An	Secondary						
Any other government sponsored plan? Yes No Applied for VA? Yes No Any other government sponsored plan? Yes No Applied for VA? Yes No Any other government sponsored plan? Yes No No Applied for VA? Yes No No Any other government sponsored plan? Yes No No Any other government sponsored plan? Yes No	State Program						
Any other government sponsored plan?	Veteran or Other Plan						
PATIENT OR PERSONAL REPRESENTATIVE SIGNATURE(S) PATIENT AUTHORIZATION 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 USA, Inc. and its affiliates, contractors and agents, including their third party patient support program service provider (collectively "Teva") for the purposes described below. 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) f needed, determining my eligibility for and coordinating financial assistance; (iv) coordinating prescription fulfillment and product replacement; vy) 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 relephonic means to the contact information on this form or on 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. 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 on	Medicaid Not applied	☐ Denied ☐ Pending	Vetera	n 🗌 Yes 🗌 No	Appl	ied for VA?	☐ Yes ☐ No
PATIENT AUTHORIZATION 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 USA, Inc. and its affiliates, contractors and agents, including their third party patient support program service provider (collectively "Teva") for the purposes described below. 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) f necessary; (iii) or neduced, 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. 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 disc			Any ot	her government sp	onsored plan	? □ Yes	□No
PATIENT AUTHORIZATION authorize my healthcare providers, pharmacies, and health plan(s) to disclose my personal health information on this form as well as information elated to my medical condition, treatment, care management, prescriptions, and health insurance to Teva Pharmaceuticals USA, Inc. and its affiliates, contractors and agents, including their third party patient support program service provider (collectively "Teva") for the purposes described below. 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) feneded, 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. 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 is disclosed pursuant to this Authorization. This Authorization will remain in effect until the Program ends. I understand that my treatment, payment for treatment, insurance enrollme					onsorea plan		
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 USA, Inc. and its affiliates, contractors and agents, including their third party patient support program service provider (collectively "Teva") for the purposes described below. 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) fineded, determining my eligibility for and coordinating financial assistance; (iv) coordinating prescription fulfillment and product replacement; (iv) 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. 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	3 PATIENT	OR PERSONAL REPR	RESENTAT	IVE SIGNATUR	·	_	
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 a nd 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.		OR PERSONAL REPR	RESENTAT	IVE SIGNATUR	·		
Patient Signature: X	PATIENT AUTHORIZATION I authorize my healthcare pro- related to my medical conditi- contractors and agents, includ- I understand that the purpose- condition ("Program"), includ- may include allowing a Teva f- if needed, determining my eli- (v) providing nursing support- Program related business act- to any future contact informa- communications, reminders, a- medication.	oviders, pharmacies, and health ion, treatment, care manageme ding their third party patient su e of this Authorization is to providing (i) enrollment in the Prografield based representative to actigibility for and coordinating fit; (vi) facilitating quality and adtivities; (viii) contacting me by cation provided by me or on my land support, for which the third	plan(s) to disc ent, prescription ipport programide me with a am; (ii) conduction cess my informancial assistation direct mail or to behalf in connal party service	close my personal headons, and health insural moservice provider (concess to services relating benefits investignation and engage wonce; (iv) coordinating exporting activities; (victor) gelectronic or teleplection with carrying approvider may received	alth information nee to Teva Phoblectively "Tevaled to my presipation and coolith my healthcapito conducting in conducting of the Programa of	n on this formarmaceuticals a") for the pu cribed medica dinating my i are provider d ulfillment and lata analytics the contact in n services, inc uneration fror	as well as information USA, Inc. and its affiliates, rposes described below. tition and/or medical nsurance coverage, which irectly, if necessary; (iii) product replacement; market research, and aformation on this form or cluding adherence related to the manufacturer of your
	PATIENT AUTHORIZATION I authorize my healthcare pro- related to my medical conditi- contractors and agents, includ- I understand that the purpose condition ("Program"), includ- may include allowing a Teva fi- if needed, determining my eli- (v) providing nursing support Program related business act- to any future contact informa- communications, reminders, a- medication. I understand that I may cance my cancellation will not applic Program ends. I understand ti- federal privacy law. I understa- directly affected if I do not sig- entitled to a copy of this signi-	oviders, pharmacies, and health ion, treatment, care manageme ding their third party patient sue of this Authorization is to providing (i) enrollment in the Prografield based representative to actigibility for and coordinating firt; (vi) facilitating quality and adtivities; (viii) contacting me by cation provided by me or on my land support, for which the third el this Authorization at any time by to any information already distination once my information is discand that my treatment, paymer gn this Authorization. However,	plan(s) to discent, prescription in prescripti	close my personal headens, and health insural mervice provider (concess to services relating benefits investignation and engage with meters (iv) coordinating exporting activities; (vi) gelectronic or teleplection with carrying of provider may receive a Teva, Attn: Authorization to this Authorization subject to redisclont, insurance enrollments.	alth information nice to Teva Phollectively "Tev ted to my president and coordinate in the prescription of it conducting conducting conducting conducting conducting around the Programe in the Programe of the Programme of the Pr	n on this formarmaceuticals a") for the purified medical dinating my in are provider dulfillment and lata analytics, the contact in services, incureration from 7613, Overland ization will reipients and region of the processive for insurance le to receive for the processive for t	as well as information USA, Inc. and its affiliates, rposes described below. Ition and/or medical Insurance coverage, which Irectly, if necessary; (iii) Insurance replacement; Insurance replacement; Insurance replacement; Insurance replacement; Insurance replacement Insurance related Insurance related In the manufacturer of your Insurance related by In

teva | Shared Solutions® for Biosimilars

ENROLLMENT FORM
PLEASE FAX COMPLETED FORM TO 866-676-4073
FOR QUESTIONS, CALL 888-587-3263

Healthcare Professional

Physician Name:		DEA#:		NPI#:			
Medical License #:		MD Tax ID #:					
Facility Name:		Group Tax ID #	Group Tax ID #:				
Address:							
City:		State:		ZIP			
Medicaid Provider # and Pin:		PTAN #:		"			
Clinical Contact:		Contact Title:					
Contact Phone:		Contact Fax:					
Billing Contact:		Contact Title:					
Contact Phone:		Contact Fax:					
Patient Name (First MI Last):	G INFORMATION			Date of Birth:			
Site of Care: Physician Office	 ☐ Facility/Hospital			Is patient being treated			
Patient Primary Diagnosis — ICI	D-10 Code: D	escription:		outpatient?:			
Patient Secondary Diagnosis —	IDC-10 Code: D	escription:	ion: □ Yes □ No				
Choose Drug Name: ☐ HERZUMA® (trastuzumab-pkrb)	for Injection ☐ TRUXIMA®	🤊 (rituximab-abbs) Injed	tion				
Therapy		Therapy PLANNED for month					
Date(s) Dose	Frequency	Date(s)	Dose	Frequency			
		''	''	"			
3 PRESCRIBER							

(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

Date: X

so that I may share this patient's health information with Teva. **STAMP SIGNATURE NOT PERMITTED - INK SIGNATURE ONLY.

CANNOT process form without signature and date



Physician Signature: X