



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)



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

ENROLLMENT APPLICATION

FOR INTERNAL USE ONLY

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: Male Female

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

Marital Status: Single Married Divorced Widowed Employment Status: Employed Self-employed Retired Unemployed

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 insurers/payers/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 if "Y"</small>	Y N
Private Insurance: _____ <small>List Insurer if "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:

<input type="checkbox"/> ADRUCIL [®] (Fluorouracil Injection, USP)	<input type="checkbox"/> GALZIN [®] Capsules (zinc acetate)	<input type="checkbox"/> Proglycem [®] (diazoxide, USP) Oral Suspension
<input type="checkbox"/> Bleomycin for Injection, USP	<input type="checkbox"/> Idarubicin HCl Injection	<input type="checkbox"/> PURINETHOL [®] (mercaptapurine) Tablets**
<input type="checkbox"/> Carboplatin for Injection, USP	<input type="checkbox"/> Ifosfamide Injection/Mesna Injection Kit	<input type="checkbox"/> QVAR [®] (Beclomethasone Dipropionate HFA)
<input type="checkbox"/> Carboplatin Lyophilized Powder for Injection	<input type="checkbox"/> Irinotecan Injection	<input type="checkbox"/> TOPOSAR [®] (Etoposide Injection, USP)
<input type="checkbox"/> Cyclosporine Capsules Modified, Cyclosporine Oral Solution Modified	<input type="checkbox"/> Leuprolide Acetate Injection	<input type="checkbox"/> VINCASAR PFS [®] (Vincristine Sulfate Injection, USP)
<input type="checkbox"/> Dacarbazine for Injection, USP	<input type="checkbox"/> Mesna Injection	<input type="checkbox"/> Vinorelbine Tartrate Injection
<input type="checkbox"/> Daunorubicin HCl Injection	<input type="checkbox"/> ORAP [®] Tablets (pimozide)	<input type="checkbox"/> Vivactil [®] (Protriptyline HCl) Tablets
<input type="checkbox"/> Epirubicin HCl Injection	<input type="checkbox"/> Paclitaxel Injection	<input type="checkbox"/> ZANOSAR [®] (Streptozocin Sterile Powder)
<input type="checkbox"/> Fludarabine Phosphate for Injection, USP (Lyophilized)	<input type="checkbox"/> Pamidronate Disodium Injection	
	<input type="checkbox"/> ProAir [®] HFA (albuterol sulfate aerosol HFA)	

** 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.

Applications 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.

TEVA PAP APP v2.5 6/09