

## FOR PATIENT

## Patient Information

First Name: Stephanie MI:  Last Name: Compton  
 Gender:  Male  Female Date of Birth: 2/9/71 SSN:   
 Address: 5217 S. Nenten Ln City, State: Lou KY ZIP: 40241  
 Phone:   Home  Mobile  Work Email:   
 Best Method to Contact:  Call  Text  Email Best Time to Contact:  Morning  Afternoon  Evening

## Insurance Information

Insurance Name: Humana  See attached insurance card  
 Plan ID #:  Group #:  Is this a secondary plan?:  Yes  No  
 Policy Holder Name: (if different from patient) Policy Holder DOB:   
 Plan Type:  Private/Commercial  Medicare Part D  Medicare Advantage  Medicaid  VA or Military  Uninsured

## FOR PHYSICIAN ONLY

## Physician Information

Physician Name: Shannon O'Brien Specialty: Oncology  
 NPI #: 1154567675 License #(s):   
 Facility Name: Norton Health East Group Tax #:  
 Address: 239 Hulffville Crosskeys Rd City, State: Sewell, NJ ZIP: 08080  
 Phone: 856 728-3636 Fax:   
 Office Contact Name: Jane Smith Contact Email:

## Clinical Information

Diagnosis Code (ICD-10): C4490 Diagnosis Description:

## Prescription

Rx:  Medicine A  Medicine B  Medicine C  
 Dosage: 2 pills, twice daily Quantity: 28 days Refills: 11

I certify that the information above is accurate and medically necessary to the best of my knowledge. I certify that I am the prescriber of this medication to the aforementioned patient and that I provided the patient with the information required to consent to this medication. I authorize the release of this information to the manufacturer for them to act on my behalf for the purposes of transmitting this prescription to the patient's selected pharmacy.

Physician Signature: Shannon O'Brien Date: 1/13/21

## FOR PATIENT

## Patient Information

First Name: Amy MI: \_\_\_\_\_ Last Name: Cummins  
 Gender:  Male  Female Date of Birth: 6/1/48 SSN: \_\_\_\_\_  
 Address: 4962 Spring St City, State: Sewell, NJ ZIP: 08080  
 Phone: 555-638-2046  Home  Mobile  Work Email: \_\_\_\_\_  
 Best Method to Contact:  Call  Text  Email Best Time to Contact:  Morning  Afternoon  Evening

## Insurance Information

Insurance Name: Medicare Phone: \_\_\_\_\_ See attached insurance card  
 Plan ID #: B6346 Group #: 546921 Is this a secondary plan?:  Yes  No  
 Policy Holder Name: \_\_\_\_\_ Policy Holder DOB: \_\_\_\_\_  
 Plan Type:  Private/Commercial  Medicare Part D  Medicare Advantage  Medicaid  VA or Military  Uninsured

## FOR PHYSICIAN ONLY

## Physician Information

Physician Name: Shannon O'Brien Specialty: Oncology  
 NPI #: 1154567675 License #(s): \_\_\_\_\_  
 Facility Name: Norton Health East Group Tax #: \_\_\_\_\_  
 Address: 239 Huffville Crosskeys Rd City, State: Sewell, NJ ZIP: 08080  
 Phone: 856 728-3636 Fax: \_\_\_\_\_  
 Office Contact Name: Jane Smith Contact Email: \_\_\_\_\_

## Clinical Information

Diagnosis Code (ICD-10): C4490 Diagnosis Description: \_\_\_\_\_

## Prescription

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Dosage: 2 pills, twice daily Quantity: 28 days Refills: 11

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Physician Signature: Shannon O'Brien

Date: 1/13/21

## FOR PATIENT

## Patient Information

First Name: Victoria

MI:

Last Name: Barrett

Gender:  Male  Female

Date of Birth: 12/19/86

SSN:

Address: 48 Charles St

City, State: Princeton NJ

ZIP: 08540

Phone: 524-136-4968

 Home  Mobile  Work

Email:

Best Method to Contact:  Call  Text  EmailBest Time to Contact:  Morning  Afternoon  Evening

## Insurance Information

Insurance Name: Aetna HMO

 See attached insurance card

Phone: 444-444-4444

Plan ID #: 44B32

Group #: 3396426

Is this a secondary plan?:  Yes  NoPolicy Holder Name:  
(if different from patient)

Policy Holder DOB:

Plan Type:  Private/Commercial  Medicare Part D  Medicare Advantage  Medicaid  VA or Military  Uninsured

## FOR PHYSICIAN ONLY

## Physician Information

Physician Name: Shannon O'Brien

Specialty: Oncology

NPI #: 1154567675

License #(s):

Facility Name: Norton Health East

Group Tax #:

Address: 239 Huffville Crosskeys Rd

City, State: Sewell, NJ

ZIP: 08080

Phone: 856 728-3636

Fax:

Office Contact Name: Jane Smith

Contact Email:

## Clinical Information

Diagnosis Code (ICD-10): C4490

Diagnosis Description:

## Prescription

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Dosage: 2 pills, twice daily

Quantity: 28 days

Refills: 11

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Physician Signature: Shannon O'Brien

Date: 1/13/21

## FOR PATIENT

## Patient Information

First Name: Marc

MI:

Last Name: JimenezGender:  Male  FemaleDate of Birth: 11/30/73

SSN:

Address: 4382 W Havens DrCity, State: New Palestine, INZIP: 46163Phone: 317-649-8895 Home  Mobile  Work

Email:

Best Method to Contact:  Call  Text  EmailBest Time to Contact:  Morning  Afternoon  Evening

## Insurance Information

Insurance Name: Anthem See attached insurance card

Phone: \_\_\_\_\_

Plan ID #:

Group #:

Is this a secondary plan?:  Yes  No

Policy Holder Name:

(If different from patient)

Policy Holder DOB: \_\_\_\_\_

Plan Type:  Private/Commercial  Medicare Part D  Medicare Advantage  Medicaid  VA or Military  Uninsured

## FOR PHYSICIAN ONLY

## Physician Information

Physician Name: Shannon O'BrienSpecialty: OncologyNPI #: 1154567675

License #(s): \_\_\_\_\_

Facility Name: Norton Health East

Group Tax #:

Address: 239 Hurffville Crosskeys RdCity, State: Sewell, NJZIP: 08080Phone: 856 728-3636

Fax: \_\_\_\_\_

Office Contact Name: Jane Smith

Contact Email: \_\_\_\_\_

## Clinical Information

Diagnosis Code (ICD-10): C4490

Diagnosis Description: \_\_\_\_\_

## Prescription

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Physician Signature: Shannon O'BrienDate: 1/13/21

## FOR PATIENT

## Patient Information

First Name: Bella

MI:

Last Name: JenningsGender:  Male  Female

Date of Birth:

SSN:

Address: 5010 CoteheleCity, State: LOU. KYZIP: 40241Phone: 555-326-1746 Home  Mobile  Work

Email:

Best Method to Contact:  Call  Text  EmailBest Time to Contact:  Morning  Afternoon  Evening

## Insurance Information

Insurance Name: Aetna HMO See attached insurance card

Phone: \_\_\_\_\_

Plan ID #:

Group #:

Is this a secondary plan?:  Yes  NoPolicy Holder Name:  
(If different from patient)

Policy Holder DOB: \_\_\_\_\_

Plan Type:  Private/Commercial  Medicare Part D  Medicare Advantage  Medicaid  VA or Military  Uninsured

## FOR PHYSICIAN ONLY

## Physician Information

Physician Name: Shannon O'BrienSpecialty: OncologyNPI #: 1154567675

License #(s): \_\_\_\_\_

Facility Name: Norton Health East

Group Tax #:

Address: 239 Huffville Crosskeys RdCity, State: Sewell, NJZIP: 08080Phone: 856 728-3636

Fax: \_\_\_\_\_

Office Contact Name: Jane Smith

Contact Email: \_\_\_\_\_

## Clinical Information

Diagnosis Code (ICD-10): C4490

Diagnosis Description: \_\_\_\_\_

## Prescription

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Physician Signature: Shannon O'BrienDate: 1/13/21

## FOR PATIENT

## Patient Information

First Name: James

MI:

Last Name: Talbott

Gender:  Male  Female

Date of Birth:

9/16/40

SSN:

Address:

City, State:

ZIP:

Phone: 555-469-1264

 Home  Mobile  Work

Email:

Best Method to Contact:  Call  Text  EmailBest Time to Contact:  Morning  Afternoon  Evening

## Insurance Information

Insurance Name: None

 See attached insurance card

Phone: \_\_\_\_\_

Plan ID #:

Group #:

Is this a secondary plan?:  Yes  NoPolicy Holder Name:  
(if different from patient)

Policy Holder DOB: \_\_\_\_\_

Plan Type:  Private/Commercial  Medicare Part D  Medicare Advantage  Medicaid  VA or Military Uninsured

## FOR PHYSICIAN ONLY

## Physician Information

Physician Name: Shannon O'Brien

Specialty: Oncology

NPI #: 1154567675

License #(s): \_\_\_\_\_

Facility Name: Norton Health East

Group Tax #:

Address: 239 Huffville Crosskeys Rd

City, State: Sewell, NJ

ZIP: 08080

Phone: 856 728-3636

Fax: \_\_\_\_\_

Office Contact Name: Jane Smith

Contact Email: \_\_\_\_\_

## Clinical Information

Diagnosis Code (ICD-10): C4490

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Physician Signature: Shannon O'Brien

Date: 1/13/21

## FOR PATIENT

## Patient Information

First Name: Andrew MI: \_\_\_\_\_ Last Name: Dwyer  
 Gender:  Male  Female Date of Birth: 7/16/70 SSN: \_\_\_\_\_  
 Address: 123 Main Street City, State: Prospect KY ZIP: 40059  
 Phone: (502) 555-1144  Home  Mobile  Work Email: \_\_\_\_\_  
 Best Method to Contact:  Call  Text  Email Best Time to Contact:  Morning  Afternoon  Evening

## Insurance Information

Insurance Name: Aetna HMO Phone: \_\_\_\_\_  
 Plan ID #: 64B32 Group #: 3396426 Is this a secondary plan?:  Yes  No  
 Policy Holder Name: N/A (If different from patient) Policy Holder DOB: / /  
 Plan Type:  Private/Commercial  Medicare Part D  Medicare Advantage  Medicaid  VA or Military  Uninsured

## FOR PHYSICIAN ONLY

## Physician Information

Physician Name: Wangjan Zhong Specialty: \_\_\_\_\_  
 NPI #: 1275670788 License #(s): \_\_\_\_\_  
 Facility Name: Baptist Health Group Tax #: \_\_\_\_\_  
 Address: 4003 Kresge Way Ste 500 City, State: Louisville KY ZIP: 40207  
 Phone: (502) 897-1466 Fax: (502) 897-1461  
 Office Contact Name: Trish Gains Contact Email: tgains@email.com

## Clinical Information

Diagnosis Code (ICD-10): C85.90 Diagnosis Description: \_\_\_\_\_

## Prescription

Rx:  Medicine A  Medicine B  Medicine C

Dosage: 1 pill by mouth daily Quantity: 28 Refills: Ø

I certify that the information above is accurate and medically necessary to the best of my knowledge. I certify that I am the prescriber of this medication to the aforementioned patient and that I provided the patient with the information required to consent to this medication. I authorize the release of this information to the manufacturer for them to act on my behalf for the purposes of transmitting this prescription to the patient's selected pharmacy.

Physician Signature: DR Zhong

Date: 2/1/21

## Patient Authorization- Demonstration

Patient Name: Patient Name Patient DOB: 5/1/85

**Information Disclosure-** I have read the below and understand the Patient Authorization and I agree to allow my information (as defined in Patient Authorization) to be used and shared as described in Authorization.

Patient Signature: [Signature] Date: 12/12/20

**Program Enrollment-** By signing below, I agree to enroll in the Patient Support Program.

Patient Signature: [Signature] Date: 12/12/20

By signing the Patient Authorization, I authorize my healthcare providers, including the pharmacies I use, and my health insurance plan(s) to disclose my personal information, including information about me (eg, my name, address) and my health, including my finances, insurance, prescriptions, pharmacy fills/claims, and medical condition ("My Information") to Company (the manufacturer of PRODUCT® and its affiliates, agents, and contractors, including the administrators of the Company Patient® Support Program, the dispensing pharmacies of Company products, and any other person or entity assisting Company in the administration of the Patient Program (collectively, the "Company Patient Team"), for the purposes listed below:

1. To investigate, verify, and determine my insurance coverage for PRODUCT
2. To provide financial assistance, and support to facilitate access to PRODUCT
3. To facilitate a voluntary training session educating on device use and successful treatment initiation
4. To determine my initial and continuing eligibility for other assistance programs
5. To contact me by phone, mail, e-mail (if my e-mail address was provided), cell phone, or text message (if my cell phone was provided) to request further information, discuss the application process, administer the Program, evaluate treatment progress and/or the effectiveness of the Program, and to conduct market research
6. For Company's internal business purposes of continuous improvement, including ongoing quality control
7. To help ensure the accuracy and completeness of my applications
8. To send me marketing information, offers, and educational materials related to PRODUCT

I understand that my pharmacy provider may receive remuneration from Company in exchange for the health information provided and/or for any therapy support services provided to me. I also understand that once My Information has been disclosed under this Authorization, federal privacy laws may no longer protect it and that it may be subject to further disclosure. I specifically authorize the Company Team to use and disclose My Information for the purposes listed above. I further understand that if I decline to sign this Authorization, that will not affect my eligibility for health plan benefits and treatment by my healthcare providers, but I will not have access to the education and services available through the Patient Support Program. I understand that I may revoke this Authorization at any time by calling 1-800-555-4465 or writing to Company. If I do revoke this Authorization, the Company Patient Team will stop accessing, using, and disclosing My Information thereafter, but the uses and disclosures previously made in reliance on the Authorization will not be deemed invalid. This Authorization expires ten (10) years from the date of my Program Enrollment signature on page 1, unless specified or mandated to be shorter by applicable state law. I understand that I am entitled to a copy of this Authorization once signed.