DARAPRIM®
(pyrimethamine) 25mg tablets

ENROLLMENT FORM
PHONE: 844-267-3323 FAX: 877-241-1365

*Indicates required field. Please complete all required fields to avoid processing delays.

This form is intended for prescriber use only. Fax both pages of the completed form to 1-877-241-1365.

☐ New Patient ☐ Current Patient

PATIENT INFORMATION

*Patient Name (Last, First):

*Date of Birth: Gender: M ☐ F ☐

*Address:

*City: *State: *Zip:

*Phone #: Cell #:

Email:

Preferred Contact Method: ☐ Phone ☐ Cell ☐ Email

Best Time to Call: ☐ Morning ☐ Afternoon ☐ Evening

Parent/Guardian (if applicable): ☐ Principal Contact

*Deliver to: ☐ Patient's Home ☐Physician's Office

PATIENT INSURANCE INFORMATION/PHARMACY BENEFIT PLAN

Please complete the fields below or include a copy of the front AND back of the patient's prescription benefit and insurance card(s).

*Primary Insurance: Pharmacy Help Desk #:

Policyholder Name: *Relationship to Patient:

*Member ID #: *Group ID #:

*Rx BIN #: *PCN #:

Secondary Insurance: Pharmacy Help Desk #:

Member ID #: Group ID #:

Rx BIN #: PCN #:

*Insurance: ☐ Medicaid ☐ Medicare ☐ Other _____

Special Instructions:

PRESCRIBER INFORMATION

*Prescriber Name (Last, First):

Prescriber Practice Title:

MD Specialty:

*NPI #: Physician Medicaid UPIN #:

State License #: DEA #:

*Address:

*City: *State: *Zip:

*Phone #: *Fax #:

*Staff Contact Name:

*Staff Contact Number: Staff Contact Email:

PATIENT DIAGNOSIS

*ICD-10 Code/Description:

*Please list any known allergies to medication or other substances:

PRESCRIPTION INFORMATION

*Patient Name (Last, First):

Drug: **Daraprim® (pyrimethamine) 25mg tablets**

*Quantity: *Refills:

*Directions:

*Start Date: Anticipated Duration:

Additional Prescription(s):

PROVIDER ATTESTATION

Prescriber signature must be the same as the prescriber name above

By signing below, I verify that the information being disclosed in this enrollment form is complete and accurate to the best of my knowledge. I understand that Armada Specialty Pharmacy Network (ASPN) reserves the right at any time and for any reason, without notice, to modify this enrollment form or to modify or discontinue any services or assistance provided through this Program. I authorize ASPN as my designated agent to use and disclose my patient's protected health information as may be necessary for treatment, payment, and healthcare operations, including to verify the accuracy of any information provided, to verify patient eligibility, to provide for payment and reimbursement, and to forward the above prescription information, by fax or other mode of delivery, to a pharmacy for fulfillment.

*Prescriber's Signature: *Date:

(No Stamps) (Dispense As Written)

*Prescriber's Signature : *Date:

(No Stamps) (Substitutions Permitted)

Please see accompanying Full Prescribing Information.

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PATIENT REPRESENTATIVE

By signing below, I authorize my Designee, listed below, to receive administrative information related to my treatment, such as appointment reminders, and to make decisions on my behalf—for which I will remain liable—regarding delivery of DARAPRIM® (pyrimethamine). Armada Health Care, LLC., and its affiliates, representatives, agents and contractors is not liable for any decision(s) made by the Designee or actions taken in reliance on such Designee decisions.

Designee Name: Relationship: Phone #:

Patient's Signature: Date:

PATIENT AUTHORIZATION

I, or my authorized representative, hereby authorize the pharmacy receiving my referral or dispensing my medication, and its affiliates, representatives, agents, and contractors (collectively, "Pharmacy"), to use and disclose all of my individually identifiable health information; protected health information including but not limited to records that may contain information created by other persons or entities, including physicians and other health care providers, as well as information regarding the use of drug and alcohol treatment services, confidential HIV/AIDS treatment, mental health services (excluding psychotherapy notes), information about my medical condition, prescription, treatment, care management, and health insurance; and any other personal information, including all demographic information, email addresses, phone numbers, and other information, in the possession or control of Pharmacy (collectively "Information"), to Armada Health Care, Inc., its affiliates, representatives, agents, and contractors, ("Armada"); Turing Pharmaceuticals, Inc., and, including any patient assistance program administrator(s) (collectively "Turing") for Daraprim.

The Information may be used and disclosed for purposes of: (1) providing, coordinating, managing, and contacting me about, my prescriptions (including medication refill and adherence reminders), treatment, patient support, and other services related to my Turing therapies including providing information to the pharmacy dispensing my medication; (2) establishing my benefits eligibility, including for any financial or reimbursement support services offered by or on behalf of Turing; (3) communicating with me and my healthcare providers, health plans, and other payers about my medical care; and (4) providing me with information about current or future products or services.

I understand that Pharmacy may receive a fee from Turing in exchange for (1) providing me with certain materials and information described above, and (2) using or disclosing certain Information pursuant to this Authorization. I also understand that once my Information has been shared with Turing or Amada, it may be re-disclosed by Turing or Armada and no longer protected by the federal Privacy Rule. However, other state and federal laws may establish continuing protections for the disclosed information and prohibit Turing or Armada from disclosing specially protected information such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.

I understand that I may revoke this Authorization at any time, in writing, by sending written notification to Armada Health Care, LLC, 100 Campus Drive, Suite 300, Florham Park, NJ, 07931. I understand that revoking this Authorization will prohibit disclosures of my information after the date the cancellation letter is received, but will not be affected disclosures made by Pharmacy to Turing or Armada in reliance on this Authorization.

I understand that signing this Authorization is voluntary. I have the right to refuse to sign this Authorization and my refusal to sign will not affect my ability to obtain treatment or my eligibility for health plan benefits, and my Information will not be released. However, I understand that I will not have access to additional patient support, financial, or related services offered by Turing. This authorization expires December 31, 2099, or at an earlier date if required by state law. I understand that I have the right to receive a copy of this Authorization.

Patient or Authorized Representative Signature: If Authorized Rep, State Basis for Authority:

Patient's Printed Name: Date:

NOTE TO RECIPIENT OF INFORMATION:

HIV Related Information: To the extent that HIV-related information has been provided to you, such information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. An oral disclosure shall be accompanied or followed by such notice within ten days.

TURING
PHARMACEUTICALS

March 2016
DAR2016038

Please see accompanying Full Prescribing Information.