patient Rx solutions
Patient Assistance

KYOWA KIRIN ProStrakan

SANCUSO® (Granisetron Transdermal System) Patch Replacement Application

ALL SECTIONS ARE REQUIRED TO BE COMPLETED

1. Patient Information

Name: _____ Date of Birth: _____ SSN: _____

Address: _____

Daytime Phone: _____ OK to leave message? ❑ Yes ❑ No

2. Reason for Replacement

❑ Chemotherapy cancelled or rescheduled

Date of Cancelled Appointment: _____ Date of Rescheduled Appointment: _____

❑ Patch did not adhere to patient's skin ❑ Other: _____

Proof of purchase is required with this application

Patient Declaration and Authorization to Share Health Information:
I authorize my health care providers, physicians, specialty distribution center, third party service provider (collectively "providers") to use, share and disclose my protected health information (PHI). This information may include spoken or written facts about my medical condition, my health insurance benefits, name, date of birth, address, telephone number(s), social security number, and/or financial information. It may include copies of records from my healthcare providers or health plans outlining my medical history and my treatments. All of this information may be considered protected health information (PHI). My PHI will be given to ProStrakan, Inc. (ProStrakan), its vendor Armada Health Care LLC and any other affiliated companies, subcontractors, vendors or partners that help with the management of the Product Replacement Program (the "Program"). My information will be treated confidentially to the extent required by law; however, I understand:

- The Program may only use my information for the purpose of evaluating my eligibility for the Program so that, if approved, I can receive a SANCUSO® (Granisetron Transdermal System) patch at no cost to replace a patch which was not fully used during my treatment
- If my PHI is disclosed federal privacy laws may no longer protect it
- I can cancel or revoke this authorization at any time by writing to the Program address above
- This authorization will expire one (1) year from the date of my signature

Patient's Certification: My signature certifies that 1) I have read and understand the above regarding the release of my PHI to the Product Replacement Program, including its use and disclosure purposes; 2) The information provided in this application is current, complete, and accurate; 3) Upon approval, I authorize ProStrakan, its vendor Armada Health Care LLC and any other affiliated companies, subcontractors, vendors and/or partners that help with the Program to forward my information to a dispensing entity on my behalf; 4) I understand that, if approved, the Program will send the medication to me; 5) I shall not seek reimbursement from any source, including any government program or third party insurer for any medication dispensed through this Program; 6) All information provided as part of this application is for the express and sole purpose of qualifying for eligibility to receive Sancuso® at no cost through the Program; 7) I understand that Program eligibility is subject to ProStrakan's discretion and ProStrakan reserves the right to modify or terminate the Program at any time without notice; 8) I hereby release and forever discharge ProStrakan and all providers involved in the Program including its vendor Armada Health Care LLC from any and all liability related to the Program.

Patient Signature _____ **Date** _____

3. Prescriber Information

Prescriber Name: _____ Specialty: _____ Professional Designation of Prescriber: _____

State License Number (SLN): _____ SLN State: _____ SLN Expiration Date: _____

Practice Name: _____

Address: _____

Office Contact Name: _____ Phone #: _____ Fax #: _____

4. Prescription Information

❑ Sancuso Patch (3.1 mg/24 hours) Quantity: 1 patch

Directions: _____

Prescriber Certification:
My signature certifies **1)** I am duly licensed and authorized under applicable law to prescribe the medication requested in this application to the patient listed above (the "Patient"); **2)** The information provided above is complete and accurate; **3)** I authorize the Program to forward the above prescription information to the appropriate pharmacy in order to dispense Sancuso to the above named patient; **4)** I understand that state law may require the pharmacy to contact me to confirm the prescription information before dispensing; and **5)** the Sancuso prescription requested is intended to replace a previous patch that was not used in treatment due to the rescheduling of chemotherapy or some other reason that prevented the patient from realizing the benefit of the product.

Prescriber Signature _____ **Date** _____
(original signature required)

Fax or mail the Product Replacement Application to:

Patient Rx Solutions Program
PO Box 325
Florham Park, NJ 07932

Phone: 1-800-6-SOLUTIONS
Fax: 1-866-694-2546