Retrophin

Thiola® (tiopronin) Rx Only — TOTAL CARE HUB

Patient Enrollment Form for THIOLA® Total Care Hub

Phone: 844-4-THIOLA (844-484-4652) — Fax 877-473-3167

PATIENT INFORMATION

Patient First Name			MI	
Last Name		Gender	M	F
Date of Birth	SS#			
Address				
City	State	ZIP		
Home Phone	Mobile Phone			
Preferred Method of Contact	Phone	E-mail		
E-mail				

FOR PATIENTS UNDER 18:

Parent/Guardian First Name			MI	
Last Name				
Address				
City	State	ZIP		
Home Phone	Mobile Phone			
E-mail				

PRIMARY INSURANCE Please attach a copy of both sides of the patient's insurance card(s)

Insurance Carrier
Customer Service Phone
Subscriber Name
Relationship to Patient
Employer Name
Subscriber Date of Birth
Subscriber ID Number
Policy/Employer/Group Number

PHARMACY BENEFITS–PRESCRIPTION DRUG CARD

Insurance Carrier	
Customer Service Phone	
Subscriber Name	Bin#
Subscriber Date of Birth	
Subscriber ID Number	
Policy/Employer/Group Number	

DIAGNOSIS INFORMATION (This is for insurance purposes only, not to suggest approved uses for indication)

Primary Diagnosis — ICD-9-CM Code — ICD-9-CM Code/Diagnosis

Date of first cystine stone — # of historical stones — Most Recent Urine Cystine levels

Other medications prescribed for cystinuria

Prescription Information: THIOLA® (tiopronin) 100 mg tablets — Prescription Date — Ship To — Patient — Physician

SEE FULL PRESCRIBING INFORMATION FOR DETAILED DOSING INSTRUCTIONS

Customized dosing directions: Take — Qty: — Number of Refills:

NY Prescribers please submit prescription on an original NY State prescription blank. For all other states, if not faxed, prescription must be submitted on a state-specific blank, if applicable for your state.

If required by your state, please indicate:

Dispense as written — Brand medically necessary — Substitution is not allowed

PHYSICIAN CERTIFICATION

By signing below, I certify that (a) the above therapy is medically necessary and that I will supervise the patient's treatment accordingly; (b) I have received the necessary authorizations, including those required by state law and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to release the above information and other health and medical information of the patient to Retrophin, Inc., and the company or companies that help Retrophin administer the THIOLA® Total Care Hub services; (c) I am prescribing the drug listed for the patient listed in this application based upon my independent medical judgment. By my signature below, I agree to receive certain reimbursement support services. I authorize Retrophin and Dohmen Life Science Services ("DLSS"), acting on behalf of Retrophin, to use the information contained in the prescription above, my name, and the name, address, and telephone number of my medical practice, and other applicable information, in order to provide me, my practice, and the patient listed in this application with the aforementioned reimbursement support services. I understand that participation in the THIOLA® Total Care Hub services described does not constitute a guarantee on the part of Retrophin or parties acting on its behalf that (1) the drug I have prescribed will be reimbursed by the patient's or any insurance program, or (2) the patient will be eligible for any patient assistance program. I appoint Retrophin and its agents to convey this prescription—electronically or otherwise—to the dispensing pharmacy.

Prescriber's Signature — Date

Prescriber NPI# — Prescriber State License #

Prescriber's full, usual, and actual signature is required – no stamps. This form cannot be processed without the prescriber's signature.

Prescriber's First Name — MI — Last Name

Address — City — State — ZIP

Phone — Fax — E-mail

Office Contact Name — Phone

Please Note: If you are faxing a prescription, it must be faxed from prescriber's facility to fax number (877) 473-3167.

Please return this form to the THIOLA® (tiopronin) Total Care Hub by faxing it to (877) 473-3167.

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PATIENT AUTHORIZATION AND RELEASE TO COLLECT, USE, AND DISCLOSE MEDICAL INFORMATION

[The patient, or the patient's authorized representative, must sign this form in order to receive THIOLA® (tiopronin) Total Care Hub support services. Before signing, the patient should review, understand, and agree to the terms of this authorization and release. If an authorized representative signs for the patient, please indicate the relationship to the patient.]

I understand that the collection, use, and disclosure of my health information are protected under law. Information contained in this Enrollment Form, such as my name, address, insurance, prescription, and medical information, is "protected health information." By signing this authorization, I agree to the collection, use, and disclosure of my protected health information as described below.

I understand that I may decline to sign this Authorization, and that doing so will not affect my ability to receive treatment with the Retrophin product or obtain insurance or insurance benefits. I also understand that by declining to sign this Authorization, I will not be able to enroll in the THIOLA® Total Care Hub program.

I understand that once information about me is released based on this authorization, federal privacy laws may not prevent the entities described below from further disclosing my information. However, I understand that such entities have agreed to use or disclose information they receive only for the purposes described in this authorization or as required by law. I understand that this authorization will remain in effect for five (5) years or until my coverage, coding, reimbursement, or other inquiry has been resolved, whichever is longer.

I also understand that I may revoke (withdraw) this Authorization at any time by sending a signed, written statement to the THIOLA® Total Care Hub by faxing it to (877) 473-3167.

If I do revoke my authorization, such revocation would end my eligibility to receive the THIOLA® Total Care Hub services. Revoking this authorization will prohibit disclosures after the date written revocation is received by the THIOLA® Total Care Hub, except to the extent that action has been taken in reliance on this authorization. This means that after I revoke this authorization, my information may be disclosed among Retrophin and the company or companies that help Retrophin administer the THIOLA® Total Care Hub services in order to maintain records of my participation, but it will not be otherwise disclosed or used.

By signing below, I authorize Retrophin and the company or companies that help Retrophin administer the services, to do the following:

1. Request and receive information from my doctor, healthcare provider, health insurer, or pharmacist necessary to investigate and resolve my coverage, coding, or reimbursement inquiry or to provide the reimbursement support service that I have requested. Information may include my medical diagnosis, condition, and treatment (including prescription information), my health insurance and my name, address and telephone number;
2. Collect, use, and disclose to each other any information that I provide to Retrophin for the purpose of investigating and resolving my coverage, coding, or reimbursement inquiry or to administer the THIOLA® Total Care Hub services, including entering and maintaining my health information in a database;
3. Contact me to discuss and receive educational and therapy or treatment support services designed for people taking THIOLA®, including nutritional support and counseling;
4. Disclose information to my treating physician, healthcare professional, or pharmacist that I have provided to Retrophin as necessary to resolve my coverage, coding, or reimbursement inquiry. By signing below, I also authorize my insurer, doctor, healthcare provider, and pharmacist to release information about my prescribed medications and medical condition requested by Retrophin and the company or companies that help Retrophin administer the services;
5. Contact my insurer, other potential funding sources, social workers, patient advocacy organizations, or patient assistance programs (e.g., the THIOLA® (tiopronin) Total Care Hub) on my behalf to determine if I may be eligible for health insurance coverage or other funds, and disclose to them information about my prescribed medications and medical condition that has been provided by me or my physician, healthcare provider, or pharmacist; and
6. Disclose any information obtained from the sources listed above to third parties, if required by law, and to conduct surveys to evaluate the effectiveness of the THIOLA® Total Care Hub program.

Retrophin agrees to protect my health information by using and disclosing my information only for the reasons listed above.

Patient's Signature		**Date**	
Print Patient's Name			
Legally Authorized Representative's Signature (if needed)			
Print Legally Authorized Representative's Name			
Relationship to Patient	**Spouse** **Legal Guardian** **Representative per Power of Attorney**		
Representative's Address			
Phone		**Mobile Phone**	

Fax this form, along with both sides of the patient's Medical and Prescription Drug Benefit cards to THIOLA® Total Care Hub at (877) 473-3167.
Retain a copy of this form in the patient's records.

Please see full Safety and Prescribing Information at www.retrophin.com.