

Matulane (procarbazine hydrochloride)

PRESCRIPTION & ENROLLMENT FORM

New patient Current patient

PATIENT INFORMATION (Include the front and back copy of the patient's insurance card)

Patient name _____
 Date of birth _____ Male Female
 Street address _____
 City _____ State _____ Zip _____
 Parent/guardian (if applicable) _____ Principle contact
 Home phone _____ Work phone _____
 Cell phone _____ Evening phone _____
 E-mail address _____
 Insurance company name _____
 Insurance company phone # _____
 Insured name _____
 Insured employer _____
 Relationship to patient _____
 Identification # _____ Policy/group # _____
 Prescription card No Yes If yes, carrier _____
 Policy # _____ Group # _____
 Eligible for Medicare? No Yes Eligible for Medicaid? No Yes

PRESCRIBER INFORMATION

Date _____ Time _____
 Prescriber name _____
 Prescriber practice title _____
 Street address _____
 City _____ State _____ Zip _____
 Phone _____ Fax _____
 License # _____ DEA # _____
 Physician Medicaid UPIN # _____ NPI# _____
 MD specialty _____

Note: This form is intended for prescriber use only.
 If faxed, the fax must come from MD office or hospital (should not be faxed by patient).

Phone: 877-534-9627 Fax: 866-889-1510

CLINICAL INFORMATION

ICD-10 code: _____
 Secondary ICD-10: _____ Other _____
 Patient height _____ in cm Patient weight _____ kg lbs
 Planned schedule of treatment: Is this part of a multidrug regimen? Yes No
 Indicate regimen MOPP BEACOPP Other _____
 Number of cycles planned _____ Current cycle number _____
 NKDA Known drug allergies _____

PRESCRIBING INFORMATION

Matulane (procarbazine hydrochloride) 50mg capsules
 Dosage: _____
 Directions (include daily, weekly, cyclic, one-time, duration of therapy, etc.)

 Quantity (number of 50 mg capsules) _____ Refills _____
 Expected date of first/next dose _____ Date of last dose _____
 Deliver product to: Office Patient home Clinic Other
 Clinic location _____

PRESCRIBER SIGNATURE

By signing below, I certify that the prescribed therapy is medically necessary.

Physician printed name _____
 Physician signature _____ Date _____
 (No stamps) (Dispense as written)
 Physician signature _____ Date _____
 (No stamps) (Substitutions permitted)
 This prescription is valid only if transmitted by means of a facsimile machine directly from the prescriber's office or place of practice.



PATIENT AUTHORIZATION

I, or my authorized representative, hereby authorize Walgreen Co., and its affiliates, representatives, agents, and contractors (collectively "Walgreens") to use and disclose all of my individually identifiable health information; protected health information (except psychotherapy notes), including but not limited to 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 Walgreens (collectively "Information"), to Leadiant Biosciences, Inc., and its affiliates, representatives, agents, and contractors, including any patient assistance program administrator(s) for Matulane™ (collectively, "Leadiant Biosciences").

The Information is being 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 Leadiant Biosciences therapies; (2) establishing my benefits eligibility, including for any financial or reimbursement support services offered by or on behalf of Leadiant Biosciences; (3) communicating with me and my healthcare providers, health plans, and other payors about my medical care; and (4) providing me with information about current or future products or services offered by Walgreens.

I understand that Walgreens will receive a fee from Leadiant Biosciences 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 Leadiant Biosciences, it might be re-disclosed by Leadiant Biosciences and privacy laws may no longer protect it. I understand that I may revoke this Authorization at any time, in writing, by sending written notification to Walgreen Co. Privacy Office, 200 Wilnot Road, Mail Stop 9000, Deerfield, Illinois 60015. I understand that my revocation is not effective to the extent that action has already been taken based on this Authorization.

I understand that signing this Authorization is voluntary. If I do not sign this form, my eligibility for health plan benefits and treatment by my healthcare providers will not change, but I will not have access to additional patient support, financial, or related services offered by Leadiant Biosciences. This Authorization will expire ten (10) years after the date on which I sign it. 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 Printed Name

Date

allianceRx

Walgreens + PRIME

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