INSTRUCTIONS FOR PRESCRIPTION AND SERVICE REQUEST FORM

AJOVY®
(fremanezumab-vfrm)
injection 225 mg/1.5 mL

Follow these steps in order for your patient to receive support from Shared Solutions®:

INSTRUCTIONS FOR PRESCRIBERS

- Ensure patient has signed and dated the **PATIENT AUTHORIZATION** in this section in order for your patient to receive support from Shared Solutions® << **REQUIRED** *(Page 1, section 4)*
- Complete the form *(Pages 1 and 2)*
- Copy the front and back of the patient's insurance card
- Sign and date the form at the bottom << **REQUIRED** *(Page 2, section 5)*
- Submit form *(Pages 1 and 2)* and a copy of the patient's insurance card to **Shared Solutions®**

Fax **1-844-257-6127**

teva

SHARED SOLUTIONS®

For nurse support, injection training, and questions about AJOVY, your patients can call 1-800-887-8100 MONDAY – FRIDAY, 8 AM – 6 PM CT

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SHARED SOLUTIONS®

Patient

1 PATIENT INFORMATION

First Name	MI	Last Name
DOB (mm/dd/yyyy)	Gender ☐ M ☐ F ☐ Unspecified	
Home Address		
City	State	ZIP
Home Phone ☐ PREFERRED	Mobile Phone ☐ PREFERRED	
Email Address		

☐ Check here if you do **not** want messages left on voicemail

CANNOT process form without this section completed

2 ASSISTANCE REQUESTED FROM SHARED SOLUTIONS®

☐ Injection Training Support

☐ Sharps Disposal Container

3 PHARMACY INFORMATION

Name of Preferred Pharmacy	
Address	
Phone Number	Fax Number

4 PATIENT AUTHORIZATION

I authorize my healthcare providers, pharmacies and health plan(s) to disclose my personal health information on this form as well as information related to my medical condition, treatment, care management, prescriptions and health insurance to Teva Pharmaceuticals USA, Inc. and its affiliates, contractors and agents, including their third party patient support program service provider (collectively "Teva") for the purposes described below.

I understand that the purpose of this Authorization is to provide me with access to services related to my prescribed medication and/or medical condition ("Program"), including (i) enrollment in the Program; (ii) conducting benefits investigation and coordinating my insurance coverage, which may include allowing a Teva field based representative to access my information and engage with my healthcare providers directly, if necessary; (iii) if needed, determining my eligibility for and coordinating financial assistance; (iv) coordinating prescription fulfillment and product replacement; (v) providing nursing support, including product administration training and education; (vi) facilitating quality and adverse event reporting activities; (vii) conducting data analytics, market research and Program related business activities; (viii) contacting me by direct mail or by electronic or telephonic means to the contact information on this form or to any future contact information provided by me or on my behalf in connection with carrying out the Program services, including adherence related communications, reminders, and support, for which the third party service provider may receive financial remuneration from the manufacturer of your medication.

I understand that I may cancel this Authorization at any time, by writing to Patient Services and Solutions, Inc., Attn: Authorizations, P.O. Box 7613, Overland Park, KS 66207, but my cancellation will not apply to any information already disclosed pursuant to this Authorization. This Authorization will remain in effect until the Program ends. I understand that once my information is disclosed, it may be subject to redisclosure by the recipients and no longer protected by federal privacy law. I understand that my treatment, payment for treatment, insurance enrollment, or eligibility for insurance benefits will not be directly affected if I do not sign this Authorization. However, if I do not sign this Authorization, I may not be able to receive Program services. I am also entitled to a copy of this signed Authorization.

☐ **By checking this box,** I certify that I am at least 18 years old and consent to receive promotional or educational messages from Teva and its affiliates and agents by direct mail and email, as well as electronic or telephonic means at the telephone number provided on this form using automated technology and/or prerecorded voice messages, to provide me with information regarding migraine, Teva products, and programs and to conduct market research. I understand my consent is not a condition of purchase. Additional terms apply: http://www.pssmobileterms.com/.

CANNOT process form without signature and date

Patient Signature ✕	Date ✕

If signed by someone other than the patient, describe legal authority to do so:

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SHARED SOLUTIONS®

Healthcare Professional

1 COMPLETE PRESCRIBER INFORMATION

Prescriber ☐ MD ☐ NP ☐ PA		NPI Number
Office Contact	Phone (215) 957-9250	Fax (215) 957-9254
Address 1151 Old York Road, Suite 200		
City Abington	State PA	ZIP 19001

CANNOT process form without this section completed

2 PATIENT INSURANCE INFORMATION (please attach a copy of the patient's pharmacy benefits card, front and back)

Beneficiary/Insurance Card Holder Name		
Patient First Name	MI	Patient Last Name
DOB (mm/dd/yyyy)	Gender ☐ M ☐ F ☐ Unspecified	
Check box if patient is uninsured ☐	Does patient have Medicare Part D benefits? ☐ Yes ☐ No	
Does patient have a pharmacy benefits card? ☐ Yes ☐ No	Rx BIN Number	Rx PCN Number
Rx Card Name		
Rx ID Number	Rx Group Number	Rx Phone Number

3 PRESCRIPTION INFORMATION

Patient First Name	MI	Patient Last Name

ICD-10 Code

Select **ONE:** AJOVY® (fremanezumab-vfrm) injection 225 mg/1.5 mL prefilled autoinjector **OR** prefilled syringe

Autoinjector
- ☐ Qty: 1 autoinjector
- ☐ Qty: 3 autoinjectors
- ☐ Qty: _____ autoinjectors

Refills: _____

Sig: Inject 225 mg (1 autoinjector) subcutaneously one time monthly **OR**

Sig: Inject 675 mg (3 autoinjectors) subcutaneously one time every three months **OR**

Sig: _____

Prefilled syringe
- ☐ Qty: 1 syringe
- ☐ Qty: 3 syringes
- ☐ Qty: _____ syringes

Refills: _____

Sig: Inject 225 mg (1 syringe) subcutaneously one time monthly **OR**

Sig: Inject 675 mg (3 syringes) subcutaneously one time every three months **OR**

Sig: _____

4 PHARMACY INFORMATION

Was this prescription sent directly to the pharmacy?
☐ Yes ☐ No

IF YES, PLEASE PROVIDE:
Pharmacy Name

Address

Phone Number | Date Submitted

5 PRESCRIBER SIGNATURE

After discussing the AJOVY® Program (including its agents, service providers, and AJOVY® dispensing pharmacies) with the patient, the patient has elected to participate in the Program. I authorize the release of medical and/or other patient information relating to AJOVY® therapy to this Program, Patient Services & Solutions, Inc., and its affiliates, designated agents and service providers, including but not limited to AJOVY® dispensing pharmacies, to use and disclose as needed for fulfillment of the prescription related to this Program, and furnish any information in this form to the insurer of the above-named patient. I also authorize the forwarding of this prescription and related information by the Program, acting as my authorized agent, to an AJOVY® dispensing pharmacy.

STAMP SIGNATURE NOT PERMITTED — INK SIGNATURE ONLY. Please attach all prescriptions on Official State Prescription form if mandated by individual state laws
The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, or hard copy prescription, etc.

CANNOT process form without signature and date

Prescriber Signature ✕ | Date ✕

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