A Guide to the PRESCRIPTION AND SERVICE REQUEST FORM FOR CINQAIR® (reslizumab) Injection

Complete a Prescription and Service Request Form for each new patient and fax it to Teva Support Solutions® at 1-844-838-2213.

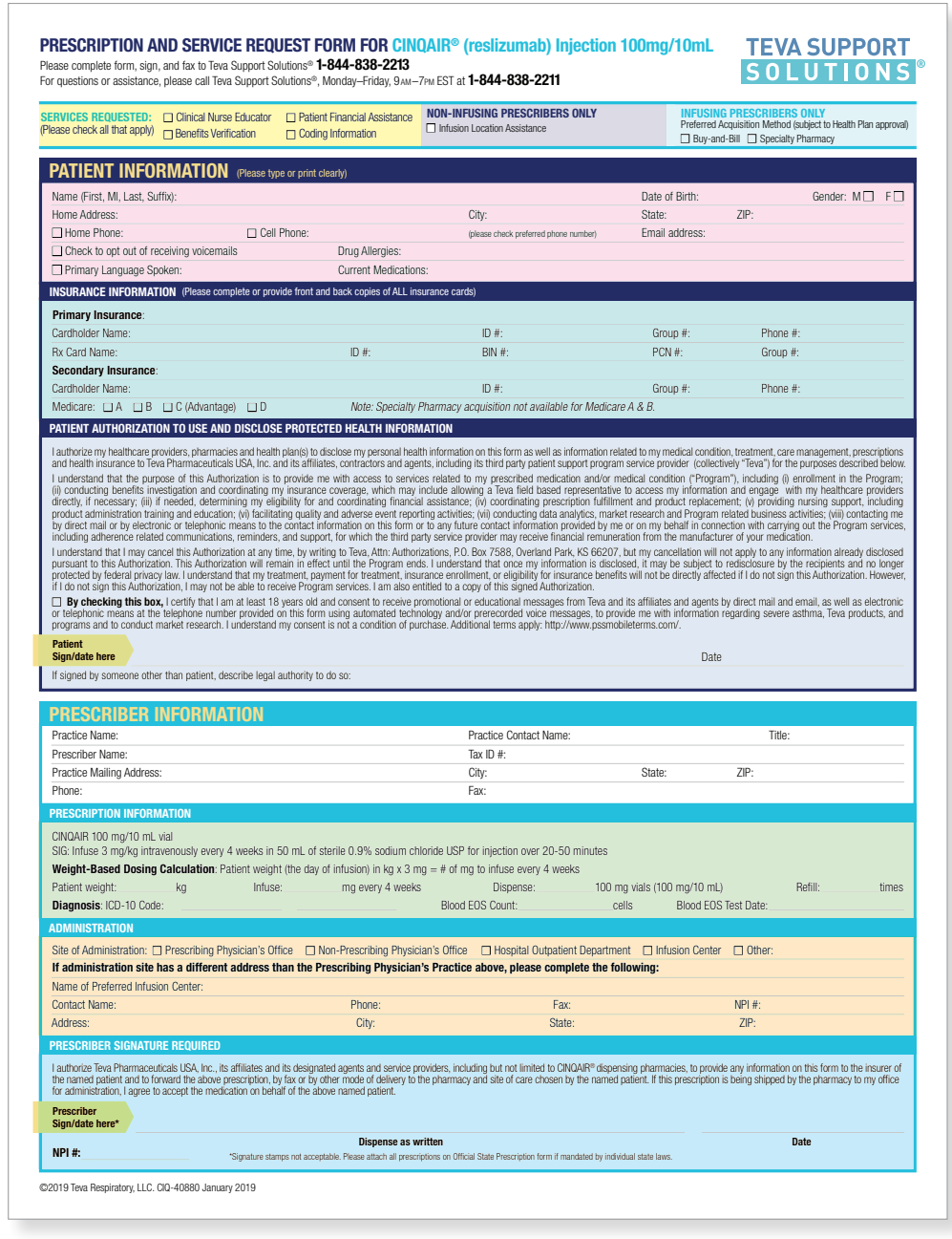
SERVICES REQUESTED	To initiate the support services offered by Teva Support Solutions®, check all the appropriate boxes.
INFUSING PRESCRIBERS ONLY	Indicate the Preferred Acquisition Method if CINQAIR® will be administered within the prescriber's office setting.
PATIENT INFORMATION	Patients will be contacted regarding their insurance coverage, financial assistance, and will receive ongoing nursing support and education.
INSURANCE INFORMATION	A Case Administrator will be assigned to verify benefits, provide information about Prior Authorization and will be available to answer any questions.
PATIENT AUTHORIZATION	Patient may opt-in to receive promotional or educational messages from Teva and affiliated agents. Be sure to include valid patient signature.
PRESCRIPTION INFORMATION	Record patient weight in kilograms and verify weight-based dosing calculation. Be sure to include Blood Eosinophil Count and test date.
ADMINISTRATION	Submit complete information about the site of administration if the patient will not receive the medication at the Prescribing Physician's Office.
PRESCRIBER AUTHORIZATION	Be sure to include valid prescriber signature and date. Prescriber must include NPI number.

Important Safety Information

WARNING: ANAPHYLAXIS

- **Anaphylaxis has been observed with CINQAIR (reslizumab) infusion in 0.3% of patients in placebo-controlled clinical studies. Anaphylaxis was reported as early as the second dose of CINQAIR.**
- **Anaphylaxis can be life-threatening. Patients should be observed for an appropriate period of time after CINQAIR administration by a healthcare professional prepared to manage anaphylaxis. Discontinue CINQAIR immediately if the patient experiences signs or symptoms of anaphylaxis.**

Please see Indications and additional Important Safety Information on back and enclosed full Prescribing Information, including Boxed WARNING for CINQAIR® (reslizumab) Injection.



PRESCRIPTION AND SERVICE REQUEST FORM FOR CINQAIR® (reslizumab) Injection 100mg/10mL

Please complete form, sign, and fax to Teva Support Solutions® **1-844-838-2213**
For questions or assistance, please call Teva Support Solutions®, Monday–Friday, 9AM–7PM EST at **1-844-838-2211**

TEVA SUPPORT SOLUTIONS®

SERVICES REQUESTED: (Please check all that apply) ☐ Clinical Nurse Educator ☐ Patient Financial Assistance ☐ Benefits Verification ☐ Coding Information
NON-INFUSING PRESCRIBERS ONLY ☐ Infusion Location Assistance
INFUSING PRESCRIBERS ONLY Preferred Acquisition Method (subject to Health Plan approval) ☐ Buy-and-Bill ☐ Specialty Pharmacy

PATIENT INFORMATION (Please type or print clearly)

Name (First, MI, Last, Suffix): Date of Birth: Gender: M☐ F☐
Home Address: City: State: ZIP:
☐ Home Phone: ☐ Cell Phone: (please check preferred phone number) Email address:
☐ Check to opt out of receiving voicemails Drug Allergies:
☐ Primary Language Spoken: Current Medications:

INSURANCE INFORMATION (Please complete or provide front and back copies of ALL insurance cards)

Primary Insurance:
Cardholder Name: ID #: Group #: Phone #:
Rx Card Name: ID #: BIN #: PCN #: Group #:
Secondary Insurance:
Cardholder Name: ID #: Group #: Phone #:
Medicare: ☐A ☐B ☐C (Advantage) ☐D *Note: Specialty Pharmacy acquisition not available for Medicare A & B.*

PATIENT AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

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 its 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 Teva, Attn: Authorizations, P.O. Box 7588, 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 severe asthma, Teva products, and programs and to conduct market research. I understand my consent is not a condition of purchase. Additional terms apply: http://www.psmobileterms.com/.

Patient Sign/date here Date
If signed by someone other than patient, describe legal authority to do so:

PRESCRIBER INFORMATION

Practice Name: Practice Contact Name: Title:
Prescriber Name: Tax ID #:
Practice Mailing Address: City: State: ZIP:
Phone: Fax:

PRESCRIPTION INFORMATION

CINQAIR 100 mg/10 mL vial
SIG: Infuse 3 mg/kg intravenously every 4 weeks in 50 mL of sterile 0.9% sodium chloride USP for injection over 20-50 minutes
Weight-Based Dosing Calculation: Patient weight (the day of infusion) in kg x 3 mg = # of mg to infuse every 4 weeks
Patient weight: kg Infuse: mg every 4 weeks Dispense: 100 mg vials (100 mg/10 mL) Refill: times
Diagnosis: ICD-10 Code: Blood EOS Count: cells Blood EOS Test Date:

ADMINISTRATION

Site of Administration: ☐ Prescribing Physician's Office ☐ Non-Prescribing Physician's Office ☐ Hospital Outpatient Department ☐ Infusion Center ☐ Other:
If administration site has a different address than the Prescribing Physician's Practice above, please complete the following:
Name of Preferred Infusion Center:
Contact Name: Phone: Fax: NPI #:
Address: City: State: ZIP:

PRESCRIBER SIGNATURE REQUIRED

I authorize Teva Pharmaceuticals USA, Inc., its affiliates and its designated agents and service providers, including but not limited to CINQAIR® dispensing pharmacies, to provide any information on this form to the insurer of the named patient and to forward the above prescription, by fax or by other mode of delivery to the pharmacy and site of care chosen by the named patient. If this prescription is being shipped by the pharmacy to my office for administration, I agree to accept the medication on behalf of the above named patient.

Prescriber Sign/date here* **Dispense as written** **Date**
NPI #:
*Signature stamps not acceptable. Please attach all prescriptions on Official State Prescription form if mandated by individual state laws.

TEVA SUPPORT SOLUTIONS®
1-844-838-2211
Monday–Friday, 9AM–7PM ET
www.TevaSupportSolutions.com

CINQAIR® (reslizumab) Injection

Indications and Usage

CINQAIR (reslizumab) Injection is an interleukin-5 antagonist monoclonal antibody (IgG4 kappa) indicated for add-on maintenance treatment of patients with severe asthma aged 18 years and older, and with an eosinophilic phenotype.

Limitations of Use: CINQAIR is **not** indicated for:
- treatment of other eosinophilic conditions
- relief of acute bronchospasm or status asthmaticus

Important Safety Information

WARNING: ANAPHYLAXIS

- **Anaphylaxis has been observed with CINQAIR (reslizumab) infusion in 0.3% of patients in placebo-controlled clinical studies. Anaphylaxis was reported as early as the second dose of CINQAIR.**
- **Anaphylaxis can be life-threatening. Patients should be observed for an appropriate period of time after CINQAIR administration by a healthcare professional prepared to manage anaphylaxis. Discontinue CINQAIR immediately if the patient experiences signs or symptoms of anaphylaxis.**

CONTRAINDICATIONS

- CINQAIR is contraindicated in patients who have known hypersensitivity to reslizumab or any of its excipients.

WARNINGS AND PRECAUTIONS

- **Acute Asthma Symptoms or Deteriorating Disease:** CINQAIR should not be used to treat acute asthma symptoms or acute exacerbations. Do not use CINQAIR to treat acute bronchospasm or status asthmaticus. Patients should seek medical advice if their asthma remains uncontrolled or worsens after initiation of treatment with CINQAIR.
- **Malignancy:** In placebo-controlled clinical studies, 6/1028 (0.6%) patients receiving 3 mg/kg CINQAIR had at least 1 malignant neoplasm reported compared to 2/730 (0.3%) patients in the placebo group. The observed malignancies in CINQAIR-treated patients were diverse in nature and without clustering of any particular tissue type. The majority of malignancies were diagnosed within less than six months of exposure to CINQAIR.
- **Reduction of Corticosteroid Dosage:** No clinical studies have been conducted to assess reduction of maintenance corticosteroid dosages following administration of CINQAIR. Do not discontinue systemic or inhaled corticosteroids abruptly upon initiation of therapy with CINQAIR. Reductions in corticosteroid dose, if appropriate, should be gradual and performed under the supervision of a physician. Reduction in corticosteroid dose may be associated with systemic withdrawal symptoms and/or unmask conditions previously suppressed by systemic corticosteroid therapy.
- **Parasitic (Helminth) Infection:** Eosinophils may be involved in the immunological response to some helminth infections. Treat patients with pre-existing helminth infections before initiating CINQAIR. If patients become infected while receiving treatment with CINQAIR and do not respond to anti-helminth treatment, discontinue treatment with CINQAIR until infection resolves.

ADVERSE REACTIONS

- Adverse reactions that occurred at ≥2% incidence and more commonly than in the placebo group included 1 event: oropharyngeal pain (2.6% vs. 2.2%).
- Elevated baseline creatine phosphokinase (CPK) was more frequent in patients randomized to CINQAIR (14%) versus placebo (9%). Transient CPK elevations in patients with normal baseline CPK values were observed more frequently with CINQAIR (20%) versus placebo (18%) during routine laboratory assessments.
- Myalgia was reported in 1% (10/1028) of patients in the CINQAIR 3 mg/kg group compared to 0.5% (4/730) of patients in the placebo group.
- Immunogenicity: In placebo-controlled studies, a treatment-emergent anti-reslizumab antibody response developed in 53/983 (5.4%) of CINQAIR-treated patients (3 mg/kg). The antibody responses were of low titer and often transient. There was no detectable impact of the antibodies on the clinical pharmacokinetics, pharmacodynamics, clinical efficacy, and safety of CINQAIR.

CINQAIR® (reslizumab) Injection 100 mg/10 mL | TEVA SUPPORT SOLUTIONS®

Please see enclosed full Prescribing Information, including Boxed WARNING for CINQAIR®.

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