SELARSDI™ (ustekinumab-aekn) Injection
PRESCRIPTION AND SERVICE REQUEST FORM

teva | Shared Solutions for Biosimilars

FAX FORM TO **833-860-0041**
OR CALL **888-587-3263**
MONDAY–FRIDAY 9AM EST TO 7PM EST

Requested Services: ☐ Benefits Verification ☐ Prior Authorization Support ☐ Commercial Copay Program ☐ Pharmacy Triage and Tracking ☐ Claims Support ☐ Appeals Support ☐ Nurse Injection Training ☐ Independent Patient Assistance Foundations Information

1 PATIENT INFORMATION (PATIENT TO COMPLETE SECTIONS 1-3)

Patient Name (First MI Last):		DOB (mm/dd/yyyy):
Primary Phone: ☐ Cell ☐ Home	Other Phone: ☐ Cell ☐ Home	Gender: ☐ Male ☐ Female ☐ Other
Email:	Preferred Time of Contact: ☐ Morning ☐ Afternoon	Preferred Language: ☐ English ☐ Spanish ☐ Other
May we leave a detailed voicemail on your personal cell phone about the status of your application, prescription, or shipments? ☐ Yes ☐ No		
Address:	City:	State: ZIP:
Caregiver/Parent/Legal Rep Name (if applicable):	Contact Phone (if applicable):	

2 INSURANCE INFORMATION

PLEASE INCLUDE COPIES OF INSURANCE CARDS, FRONT AND BACK*

☐ Private Commercial ☐ Medicare ☐ Medicaid ☐ VA ☐ Uninsured

Primary Insurance Name:		Rx Insurance Name:	
Insurance ID #:	Group #:	Rx ID #:	Group #:
Primary Insurance Phone:		Rx Insurance Phone:	
Subscriber: ☐ Self ☐ Other–Name:		DOB:	Relationship to Patient:
Secondary Insurance Name:		Secondary Insurance ID#:	
Secondary Insurance Phone:		Group #:	
Subscriber: ☐ Self ☐ Other–Name:		DOB:	Relationship to Patient:

3 PATIENT/PARENT/LEGAL REPRESENTATIVE SIGNATURE(S) — REQUIRED FOR SERVICES

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, 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 provider 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; (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 501847, San Diego, CA 92150-1847, 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.

Patient/Legal Rep Signature:	Date:
If signed by someone other than the patient, print name and relationship:	

PARENT/LEGAL GUARDIAN PATIENT AUTHORIZATION

As the patient's parent or legal guardian, I have read and understand the above Patient Authorization. I authorize all disclosures, access to services, and cancellation conditions outlined in the Patient Authorization above on behalf of the patient. I attest to possessing the legal authority to make these authorizations on behalf of the patient.

Patient's Parent/Legal Guardian Signature:	Date:
Print name and relationship:	

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4 PHYSICIAN INFORMATION (PHYSICIAN TO COMPLETE SECTIONS 4-8)

Physician Name:	NPI #:	Tax ID #:
Office Contact Name:	Contact Phone:	Contact Fax:
Facility Name:		
Address:	City:	State: ZIP:

If administering SELARSDI intravenous (IV) induction dose, indicate infusion location:
☐ Prescriber's office above ☐ Infusion site below ☐ IV not needed (do not complete section 5)

5 INFUSION SITE INFORMATION (ONLY COMPLETE IF DIFFERENT THAN PHYSICIAN'S OFFICE ABOVE)

Practice/Facility Name:	NPI #:	Tax ID #:
Infusion Physician Name:	Site of Care: ☐ Infusion Center ☐ Hospital Outpatient ☐ Non-prescriber's Office ☐ Other	
Address:	City:	State: ZIP:
Practice Contact Name:	Contact Phone:	Contact Fax:

6 PREFERRED SPECIALTY PHARMACY (ONLY COMPLETE IF RX TRIAGE AND TRACKING REQUESTED)

Would you like the patient's SELARSDI prescription to be triaged to a specialty pharmacy (SP)? ☐ Yes ☐ No
If No, please continue to complete section 7. Teva **Shared Solutions**® for Biosimilars will conduct the requested services but will not triage the prescription to the specialty pharmacy.

If Yes, provide the preferred SP name:	SP Phone:	SP Fax:

NOTE: If the preferred SP is NOT in-network with the patient's plan, **Shared Solutions** will contact the patient for their choice of an in-network SP prior to triage.

7 PRESCRIPTION INFORMATION FOR SELARSDI

Please complete this section regardless of Rx triage preference. Product information is required for benefit research and enrollment into services.

Patient Name (First MI Last):	DOB (mm/dd/yyyy):	Patient's Weight: _____ ☐ lbs ☐ kg
Primary Diagnosis Code:	Secondary Diagnosis Code:	

Has the patient taken Stelara® (ustekinumab) or another ustekinumab biosimilar before? ☐ Yes ☐ No If Yes, date of last dose: _____

PLAQUE PSORIASIS OR PSORIATIC ARTHRITIS

Vial starter doses weeks 0 and 4: ☐ Two 45 mg vials ☐ Four 45 mg vials	Prefilled syringe (PFS) starter doses weeks 0 and 4: ☐ Two 45 mg PFS ☐ Two 90 mg PFS
Vial maintenance therapy every 12 weeks: ☐ One 45 mg vial; # of refills:_____ ☐ Two 45 mg vials; # of refills:_____	PFS maintenance therapy every 12 weeks: ☐ One 45 mg PFS; # of refills:_____ ☐ One 90 mg PFS; # of refills:_____

CROHN'S DISEASE OR ULCERATIVE COLITIS

Has the patient completed the SELARSDI IV induction dose? ☐ Yes ☐ No
If Yes, provide date of IV infusion:_____

Will physician buy and bill the IV infusion? ☐ Yes ☐ No If No, please complete the IV prescription to the right	IV induction infusion at week 0 ☑ 260 mg (2 x 130 mg/26 mL vials) ☐ 390 mg (3 x 130 mg/26 mL vials) ☐ 520 mg (4 x 130 mg/26 mL vials)
Vial Maintenance Therapy every 8 weeks ☐ Two 45 mg vials; # of refills:_____	Prefilled Syringe (PFS) Maintenance Therapy every 8 weeks: ☐ One 90 mg PFS; # of refills:_____ ☐ Two 45 mg PFS; # of refills:_____

SHIPMENT DIRECTIONS: Ship the prescription to ☐ Patient ☐ Physician ☐ Infusion Site ☐ Other: _____

NOTE: SELARSDI Prefilled Syringe injections are self-administered or given by a caregiver. The patient or caregiver should be trained by a healthcare professional. **Shared Solutions** provides injection education virtually or telephonically to all eligible SELARSDI patients when they opt in for Nurse Injection Training.

8 PRESCRIBER SIGNATURE

After discussing the Program for my prescribed medication and/or medical condition (including its agents, service providers, and 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 therapy to this Program, Teva Pharmaceuticals, Inc., its affiliates and its designated agents and service providers (collectively, "Teva"), 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 understand that Teva reserves the right to modify or terminate this Program at any time for any reason without any prior notice. I understand that I am under no obligation to prescribe a specific drug and I have not received, nor will I receive any benefit, for prescribing a specific drug. I certify that I have a signed copy on file of my patient's current and completed Patient Authorization so that I may share this patient's health information with Teva.

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.

Prescriber Signature:	Date: