Radius®

TYMLOS® (abaloparatide) Patient Enrollment and Prescription Form

Phone: 1-866-896-5674 | Fax: 1-800-910-4610

Include front and back copies of insurance cards (Medical AND Pharmacy, if separate) with each submission

SECTION 1: PATIENT INFORMATION

First Name: _____ Last Name: _____ Date of Birth: _____ Gender: [ ] F [ ] M

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ [ ] *check if preferred number* Mobile Phone: _____ [ ] *check if preferred number*

Patient Email: _____ Caregiver Name (if applicable): _____

SECTION 2: CLINICAL INFORMATION *Important information intended to assist with the Prior Authorization process*

ICD-10 DIAGNOSIS CODE *(required)*:

[ ] M80._____(Postmenopausal osteoporosis with current pathological fracture)

[ ] M81._____(Postmenopausal osteoporosis without current pathological fracture)

CLINICAL HISTORY:

[ ] History of fracture Date of Most Recent Fracture: _____ Fracture Site: [ ] Spine [ ] Hip

Lowest T-Score: _____ [ ] Pelvis [ ] Other: _____

PRIOR TREATMENT(S): *check all that apply*

[ ] Alendronate (Fosamax®) [ ] Calcitonin (Miacalcin®, Fortical®) [ ] Denosumab (Prolia®)

[ ] Ibandronate (Boniva®) [ ] Raloxifene (Evista®) [ ] Risedronate (Actonel®, Atelvia®)

[ ] Romosozumab (Evenity®) [ ] Teriparatide (Forteo®) [ ] Zoledronate (Reclast®)

[ ] Abaloparatide (Tymlos®) Other: _____

SECTION 3: PRESCRIPTION INFORMATION T*o be a valid prescription, this section must be complete and accurate*

Product Name: TYMLOS® (abaloparatide) 3120mcg/1.56ml Pen-injector

Directions: Inject 80mcg subcutaneously once daily, as directed

Dispense Quantity: [ ] 3 pens, 90-day supply OR [ ] 1 pen, 30-day supply **Refills:** [ ] 3 for 90-day supply OR [ ] 11 for 30-day supply

Needles: 31G X 5/16”

Dispense Quantity: [ ] 90-day supply OR [ ] 30-day supply **Refills:** [ ] 3 for 90-day supply OR [ ] 11 for 30-day supply

HCP-Preferred Specialty Pharmacy (must be in-network): _____

SECTION 4: PRESCRIBER INFORMATION *(Asterisk fields are required)*

Prescriber First Name*: _____ Prescriber Last Name*: _____ NPI Number*: _____-_____

Practice Name: _____ Office Phone: _____ Office Fax: _____

Street Address*: _____ City*: _____ State*: _____ Zip*: _____

Office Contact Name: _____ Office Contact Phone (with extension) _____

Office Contact Email: _____

Prescriber Declaration (Enrollment request cannot be processed without signed Prescriber Declaration)

I certify that the patient and physician information contained in this form is complete and accurate to the best of my knowledge. I further certify that TYMLOS is medically necessary, and I will be supervising the patient’s treatment. I attest that I have obtained all necessary authorizations and consents, including a signed HIPAA authorization, to disclose the patient’s information, including protected health information, to Radius Health, and parties working with Radius Health, to facilitate insurance coverage for the product, initiating therapy, dispensing therapy, and administering the Patient Support Program. I affirm that the patient has been informed and agrees that (1) information disclosed on this form may no longer be protected by federal privacy law and may be redisclosed, and (2) authorization is voluntary and refusal to consent will not affect the patient’s ability to obtain treatment or insurance benefits. I authorize the forwarding of this prescription to a dispensing specialty pharmacy. I will not seek reimbursement from any third-party payer, patient or other person or entity for any product resulting from this form.

I am licensed to prescribe the product listed on this form, and the prescription complies with my state-specific prescribing.

***Prescriber Signature:** _____ **[ ] Substitution Allowed** **Date:** _____

[ ] Dispense as Written

Please include any special instructions as required by your state: _____

Radius®

PATIENT AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

I authorize my healthcare providers and staff, my health insurers, health plan or programs that provide me healthcare benefits, and any pharmacy that dispenses my medication (together "Disclosing Parties") to disclose to Radius Health, Inc. ("Radius"), its agents, and third-party contractors or service providers for the Radius Patient Support Program, including vendors providing relevant patient education services ("Program") (together the "Alliance"), health information about me, including information related to my medical condition, treatment, and insurance, and health, described as "My Information", to help the Alliance facilitate my health insurance coverage for TYMLOS® (abaloparatide) ("TYMLOS"), obtain prior authorization information, assist with appeals of denied claims, and send my prescription to a pharmacy. I further authorize the Alliance to de-identify My Information and use it for business analytics or other commercial purposes.

I also authorize the Alliance to use My Information to: (i) enroll me in the Program; and (ii) provide me with support services and materials related to the Program and/or my medication such as a patient starter kit, financial assistance, compliance support, and other related services and materials. I understand that the Alliance may share My Information with my healthcare provider, insurance provider, and/or pharmacy as part of the Program. I understand that the Disclosing Parties may receive remuneration in exchange for disclosing My Information to the Alliance. To provide these services, I authorize the Alliance to contact me by mail, email, fax, telephone call, text message (including calls and text messages made with an automatic telephone dialing system or a prerecorded voice), and other mutually agreed upon means.

I understand that I do not have to sign this Authorization and this will not affect my ability to obtain treatment, insurance coverage, or Radius medications, but will restrict my ability to participate in the Program. I understand that once disclosed, My Information may no longer be protected by applicable privacy laws. For more information about how Radius collects, uses, and discloses My Information, I can visit: https://radiuspharm.com/privacy-policy/.

I understand that unless a shorter period is required by the law of my state of residence, this Authorization shall remain in effect for a period of five (5) years or until my participation in the Program ends unless I withdraw (take back) this Authorization before then. I understand that I may withdraw this Authorization at any time, except to the extent action has been taken in reliance on it, by mailing Radius Patient Support, 6000 Park Lane Drive, Pittsburgh, PA 15275 or faxing a written request to 1-800-910-4610. I understand that withdrawing this authorization will not affect the ability of the Alliance to use and disclose any of My Information that it has already received.

I understand that I am entitled to a copy of this Authorization.

By signing below, I certify that I have read, understand, and agree to the terms and conditions of the Patient Authorization.

Patient's Name (Printed) _____ Date: _____

Patient, or Personal Representative, Signature _____

Personal Representative's Description of Authority (if applicable):_____