CHIESI
CAREDIRECT

Bronchitol® (mannitol) inhalation powder | Service Request & Prescription

Phone: 1-888-865-1222
Fax this form to: 1-866-410-6241
E-mail: chiesicaredirect@caremetx.com

STEP 1: Complete Patient Information

Full Name (First, M.I., Last): _____

DOB: ____/____/____ Sex: ❑ Male ❑ Female

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Caregiver/Guardian: _____ Relationship: _____

Caregiver/Guardian Phone: _____

STEP 2: Complete Insurance Information (Attach copy of insurance card-front & back)

Primary Insurance: _____

ID# _____ Group #: _____

Secondary Insurance: _____

ID# _____ Group #: _____

STEP 3: Complete Physician Information

Name: _____

Contact Name: _____

Practice Name/Institution/Department: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

State Medical Lic. #: _____ NPI #: _____

STEP 4: Provide Brief Medical History

Diagnosis code: ❑ _____ ❑ Other Diagnosis: _____

I attest that the patient has passed the BRONCHITOL Tolerance Test ❑ Yes

STEP 5: Prescription and Statement of Medical Necessity

Rx ❑ **BRONCHITOL®** (mannitol) inhalation powder ❑ SIG: Dose: 400mg (one blister pack of 10 capsules BID)

Quantity: 28 day supply Refills: _____

❑ Other SIG: _____

STEP 5 Continued: Specialty Pharmacy Information

> **Specialty Pharmacy Network:** BRONCHITOL is available through a limited specialty pharmacy network.

Please select the Specialty Pharmacy (SP) where the e-prescription for 28-day supply of BRONCHITOL was sent. Chiesi CareDirect will coordinate with SP to provide support services.

❑ Accredo/ESI ❑ AllianceRX Walgreen's Prime ❑ CVS Caremark Specialty ❑ Fairview Specialty

❑ Maxor Specialty Pharmacy ❑ Kroger Specialty Pharmacy ❑ UNC Specialty Pharmacy

I certify that the above therapy is medically necessary and that the information provided is accurate to the best of my knowledge. By my signature, I also acknowledge that I have obtained the patient's authorization to release the above information and such other information as may be required by Chiesi and its employees or agents to assist in obtaining coverage for BRONCHITOL and to assist in initiating or continuing BRONCHITOL therapy. I appoint CareMetx, LLC, on my behalf, to convey this prescription to the dispensing pharmacy. I also consent to the processing, by Chiesi and its agents, of my personal information that I provide in relation to this program for the purpose of facilitating the program and meeting legal obligations. I also understand that I may have rights that allow me to ask Chiesi to stop processing my personal information, edit my personal information, or delete my personal information. To exercise these rights, I can contact Chiesi at 1-888-203-1064 or at us.privacy@chiesi.com.

Prescriber's signature: _____ **Date:** _____

STEP 6: HIPAA Authorization and Consent to Communications

I authorize my health plan, physician, health care professional, hospital, clinic, pharmacy or other health care provider to disclose my personal health information, including information relating to my medical condition, treatment, care management and health insurance, as well as all information provided on this form and any prescription ("Personal Health Information"), to Chiesi USA., Inc., its subsidiaries, affiliates, representatives, agents and contractors ("Chiesi CareDirect") for the following purposes, including investigating insurance coverage, fulfilling and coordinating delivery, assisting with product training providing product support, providing patient support, and any internal use by Chiesi. I understand that my information disclosed under this authorization may be re disclosed by Chiesi and, in some instances, no longer protected by federal or state privacy laws. I understand that I may refuse to sign this authorization, and my treating providers and health plans may not condition current or future treatment, payment, or eligibility for benefits on my provision of this authorization. I understand that I am entitled to a copy of this authorization. I understand that I may cancel this authorization at any time by mailing a letter request such cancellation to Chiesi CareDirect®, 6931 Arlington Rd, Suite 308, Bethesda, MD 20814, but that this cancellation will not apply to any information already used or disclosed through this authorization. This authorization expires two (2) years from the date signed below unless a shorter time is required by law or unless you withdraw your authorization. I understand that pharmacy providers may receive remuneration for disclosing my Personal Health Information pursuant to this authorization. I also understand that I or Chiesi CareDirect, may revoke the permission to authorize pharmacy providers' to use my Personal Health Information in communication with me about the drug that has been prescribed for me and understand that they may receive a fee for such communications.

Patient's signature: _____ **Date:** _____

If you are signing this Authorization as a personal representative of the person to receive BRONCHITOL therapy, please describe authority to sign for patient (e.g. "legal guardian"):

Parent/Guardian/Legal Representative Signature: _____

Chiesi CareDirect may contact me by mail, e-mail, 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 ("communication channels"). I understand that the frequency of these messages will vary. By signing below, I hereby agree that Chiesi may communicate with me via communication channels at the email address and/or mobile telephone number previously provided by me to Chiesi and/or my healthcare provider. I understand that my consent to receive calls, emails, and/or text messages is not a condition of my obtaining other health care services from my healthcare provider. I understand and acknowledge that communications transmitted via unencrypted email, text message or over an open network may be inherently unsecure, and there is no assurance of confidentiality for information communicated in this manner. I also understand that emails and text messages have inherent privacy risks, especially when access to my computer or mobile device is not password protected. I further understand that my emails and text messages may be accessed by my employer, depending on the access I have provided to my employer. Nevertheless, I want Chiesi to communicate with me via communication channels as detailed herein. I understand that messages transmitted pursuant to this consent will be subject to Chiesi's Terms of Use and Privacy Policy. I understand that I will be able to revoke this consent (if it pertains to text messages) by replying "STOP" to a program text message or (if it pertains to email messages) by following the instructions in an email message to unsubscribe or by contacting Chiesi CareDirect at 1-888-865-1222 or at chiesicaredirect@caremetx.com. For text messages, standard message and data rates may apply.

Patient's signature: _____ **Date:** _____

If you are signing this Authorization as a personal representative of the person to receive BRONCHITOL therapy, please describe authority to sign for patient (e.g. "legal guardian"):

Parent/Guardian/Legal Representative Signature: _____