PEDIATRIC PRESCRIPTION AND SERVICE REQUEST FORM
SIMLANDI® (adalimumab-ryvk) injection

teva | Shared Solutions® for Biosimilars

ENROLLMENT FORM
PLEASE FAX COMPLETED FORM TO **866-676-4073**
FOR QUESTIONS, CALL **888-587-3263**

Patient

Requested Services: ☐ Benefits Verification ☐ Prior Authorization Support ☐ Commercial Copay Program ☐ Appeals Support ☐ Injection Training

1 PATIENT INFORMATION (PARENT/LEGAL GUARDIAN TO COMPLETE SECTIONS 1-3)

Patient Name (First MI Last):		
Patient DOB (mm/dd/yyyy):		
Parent or Guardian Name:		
Relationship to Patient:	Parent/Guardian Phone:	
Address:		
City:	State:	ZIP:
Preferred Language: ☐ English ☐ Spanish ☐ Other	Gender: ☐ Male ☐ Female ☐ Unspecified	

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2 INSURANCE INFORMATION

PLEASE INCLUDE COPIES OF INSURANCE CARDS, FRONT AND BACK*

☐ Medicare ☐ Medicaid ☐ VA ☐ Other government-sponsored plan

Cardholder Name:		Rx Insurance Name:	
Medical Insurance Name:		Rx ID #:	Rx Group #:
Medical Insurance ID #:	Group #:	Rx BIN #:	Rx PCN #:

3 PATIENT'S PARENT/LEGAL GUARDIAN SIGNATURE(S)

PATIENT AUTHORIZATION

As the patient's parent or legal guardian, I authorize the patient's healthcare providers, pharmacies, and health plan(s) to disclose the patient's personal health information on this form as well as information related to the patient's 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 the patient with access to services related to the patient's prescribed medication and/or medical condition ("Program"), including (i) enrollment in the Program; (ii) conducting benefits investigation and coordinating insurance coverage, which may include allowing a Teva field based representative to access the patient's information and engage with the patient's healthcare provider directly, if necessary; (iii) if needed, determining the patient's 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 by direct mail or by electronic or telephonic means to the contact information on this form or to any future contact information provided 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 the patient's medication.

I understand that I may cancel this Authorization at any time, by writing to Teva, 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 the patient's information is disclosed, it may be subject to redisclosure by the recipients and no longer protected by federal privacy law. I understand that the patient's 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, the patient may not be able to receive Program services. I am also entitled to a copy of this signed Authorization.

Patient's Parent/Legal Guardian Signature: ✕	Date: ✕

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Healthcare Professional

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

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

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2 PRESCRIPTION INFORMATION

Patient Name (First MI Last): | DOB (mm/dd/yyyy):

☐ New ☐ Switch ☐ Restart

DIAGNOSIS ☐ Juvenile Idiopathic Arthritis ☐ Pediatric Crohn's Disease

PHARMACY PRESCRIPTION Please select the medication, and complete and sign the corresponding pharmacy prescription

Patient's preferred Specialty Pharmacy*_____Number of refills_____ ☐ Do not send to Specialty Pharmacy

*Prescription will be triaged to preferred pharmacy unless otherwise dictated by insurance mandate and/or patient preference

JUVENILE IDIOPATHIC ARTHRITIS (2 Years of Age and older)

Select Recommended Dose
30 kg (66 lbs) and greater

SIMLANDI Autoinjector 40 mg/0.4 mL	☐ 40 mg SC every other week

PEDIATRIC CROHN'S DISEASE (6 Years of Age and Older)

Select Recommended Dose(s)
40 kg (88 lbs) and greater

SIMLANDI Autoinjector 40 mg/0.4 mL	☐ **Initial dose:** 160 mg SC on Day 1 (single dose or split over two consecutive days), followed by 80 mg SC on Day 15	☐ **Maintenance dose:** 40 mg SC every other week starting on Day 29

3 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 and/or their parent or legal guardian, the patient and/or their parent or legal guardian 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: ✕

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