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 [ ] Pelvis [ ] Other: ____________

Lowest T-Score: ____________________

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 *To 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

Sharps Container: [ ]

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®

AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL 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 Access Support Services program, including vendors providing relevant patient education services ("Program") (together - the "Alliance") personal health information ("PHI") about me, or my legal dependents, as applicable, including, but not limited to, my medical diagnosis, condition, treatment (including prescription information), health insurance information, financial information, demographic information, and contact information, as provided herein.

I authorize such disclosures so that Alliance may use and share my PHI for the following purposes:

- 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;
- to provide product support services for TYMLOS, either by Alliance or its contractors and vendors, including, but not limited to, copay assistance, reimbursement support, and other forms of patient assistance;
- to provide information, training, and education related to the use of Radius Health, Inc.'s products, either by Alliance or its contractors and vendors;
- communicating with me by mail, email, text message, telephone, or other means about my medical condition, treatment, care management, and health insurance;
- communicating with me by mail, email, text message, telephone, or other means about current or future promotional or marketing programs and events;
- internal use by Alliance, including data analysis, to evaluate services and to improve future products and services;
- to contact me about my interest in participating in market research;
- to contact me about participation in a mentor program.

I authorize Alliance to use my PHI for these purposes and to share my PHI in connection with these purposes, including with my healthcare providers, clinical product educators, insurance providers, and pharmacy, and their representatives, in order for them to coordinate my benefits, provide, when applicable, reimbursement support, investigate my insurance coverage, and help with financial assistance for Radius Health, Inc. products. I understand that once my PHI is shared, the information could be re-disclosed, but that the intent is to use my PHI only for the purposes listed above.

I understand that I do not have to sign this Authorization in order to receive healthcare, payment for healthcare, or be eligible for healthcare benefits, but will restrict my ability to participate in the Program.

This Authorization expires five (5) years from the date of my signature below unless otherwise required by law.

- I agree that if I reside in the state of Maryland, this form will be valid for no longer than 1 year from the date signed
- If I reside in California, I also have the right to access my PHI, update my PHI if it is incorrect, or to request that Alliance delete or limit its use of my PHI, although deletion is not required under certain circumstances. To exercise any of these rights, I must send a written notice by mail to the address or email address provided below.

I understand that I may revoke this authorization by sending a written notice of revocation to Alliance at **Radius Patient Support, 6000 Park Lane Drive, Pittsburgh, PA 15275,** or by sending an email to radiusaccess@radiuspharm.com, or faxing a written request to **1-800-910-4610**. I understand that if I do revoke the Authorization, that will not invalidate any uses or disclosures of my PHI made in reliance on the Authorization prior to the receipt by Alliance of my notice of revocation. For more information about how Alliance collects, uses, and protects my PHI, I can visit https://radiuspharm.com/privacy-policy/.

I understand that I am entitled to receive a copy of this Authorization over the time it is valid. I certify that I am at least eighteen (18) years of age.

By signing below, I certify that I have read and agree to the above.

Patient's Name (Printed) ____ Date: ________________

Patient, or Personal Representative, Signature ____

Personal Representative's Description of Authority (if applicable) _______________________________

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