Together With Tymlos (abaloparatide) injection
Patient Enrollment Form

Together with Tymlos Patient Support Program

- **Prescribers** and **Patients** must review, complete, and sign this form
- Fax all pages, including copies of the front and back of patient insurance card, to ***Together With Tymlos***: 1-800-910-4610

All form fields preceded by an asterisk (*) are optional.

Patient Information

Patient Name
Last: _____ First: _____
Street Address: _____ City: _____ State: _____ Zip: _____
Date of Birth: _____ Social Security Number: _____ Male ☐ Female ☐
Primary Phone: _____ *Secondary Phone: _____
*Email Address: _____

Primary Medical Insurance Information

Patient Is Uninsured ☐ Copy of Insurance Card (Front and Back) Attached: Yes ☐ No ☐
Name of Primary Insurer: _____ *Insurer Telephone: _____
Policy Number: _____ *Group Number: _____ Policyholder Name: _____
Policyholder Date of Birth: _____ Policyholder Relationship to Patient: _____

Pharmacy Benefit Manager (PBM) Insurance Information

Copy of Insurance Card (Front and Back) Attached: Yes ☐ No ☐ Name of PBM: _____
*PBM Telephone: _____ PBM Member ID Number: _____
PCN: _____ BIN: _____ *PBM Group Number: _____
Policyholder Name: _____
Policyholder Date of Birth: _____ Policyholder Relationship to Patient: _____

Patient Medical Information

Patient Diagnosis ICD-10 Code:
☐ M81.0 *(Postmenopausal osteoporosis without current pathological fracture)*
☐ M80.0 _____ *(Postmenopausal osteoporosis with current pathological fracture)*

Prior Postmenopausal Osteoporosis Therapy and Reason for Discontinuation: _____
_____
Pertinent Medical History: _____
Allergies: _____ *DXA Score: _____

Prescriber Information

Prescriber Name
Last: _____ First: _____
*Primary Specialty: _____ Practice Name: _____
Practice Street Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____ State License Number: _____ DEA Number: _____
Tax ID Number: _____ NPI Number: _____ *Group NPI Number: _____
Office Contact Name (Last, First): _____
Office Contact Email: _____

Prescription is valid only if received in accordance with applicable state requirements

Prescription Information

The prescription information below must be complete and accurate in order for medication to be sent to your patient.

Product Name: TYMLOS™ (abaloparatide) injection 80mcg

Directions: Daily, subcutaneous 80mcg injection

Dispense Quantity:
☐ Thirty (30) days
☐ Ninety (90) days

Refills:
☐ No Refills
☐ Refills (specify quantity): _____

Ancillary Supplies:
☐ One hundred (100) day needle supply
☐ Sharps container

Prescriber Declaration

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

I certify that the patient and physician information contained in this enrollment form is complete and accurate to the best of my knowledge. I have prescribed TYMLOS™ based on my judgment of medical necessity and I will be supervising the patient's treatment. I have received the necessary authorization prior to the transmittal of health information to Radius Health, Inc., and parties working with Radius Health, Inc., to perform a preliminary assessment of insurance verification and determine patient eligibility for the ***Together With Tymlos*** Patient Support Program. I authorize the forwarding of this prescription to a dispensing specialty pharmacy on behalf of myself and the patient. I understand that neither I nor the patient should seek reimbursement for any free product received under the program.

Prescriber Signature: _____ Date: _____
(No Stamps Accepted)

☐ Dispense as Written (No Substitution Permitted)

Patient Consent Form for Patient to Read and Sign

Together With Tymlos (abaloparatide) injection Program Enrollment

☐ Sign me up! Details below.

Enrollment: I am enrolling in the ***Together With Tymlos*** Patient Support Program, from here on referred to as the "Program," and authorize Radius Health, Inc., and their agents, specified as the "Alliance," to provide me services under the Program as described in the Program Enrollment Form and those that may be added in the future. Such services include:

- Coverage support
- Medication dispensing support
- ***Together With Tymlos*** Clinical Educator Network
  - Disease and medication education
  - Medication and adherence communications
  - Injection training
- Savings offer, if eligible*
- And other online support, education, and assistance services (together, the "Services")

*If confirmed as eligible, understanding that Savings information will be sent to my designated specialty pharmacy/in-network specialty pharmacy along with my prescription, and any assistance with my applicable cost-sharing or co-payment for TYMLOS will be made in accordance with the Program terms and conditions.

Information Sharing: I further authorize the Alliance to de-identify my health information and use it in performing research, education, business analytics, marketing studies, or for other commercial purposes. I understand that members of the Alliance may share identifiable health information with one another in order to de-identify it for these purposes and as needed to perform the Services or to send the Communications listed below. I understand and agree that the Alliance may use my health information for these purposes and may share my health information with my doctors, specialty pharmacies, and insurers.

I understand that I do not have to enroll in the Program or receive the Communications, and that I can still receive TYMLOS, as prescribed by my physician. I may opt out of receiving Communications, individual support services offered by the Program, including the TYMLOS Savings, or opt out of the Program entirely at any time by notifying a Program representative by telephone at 1-866-896-5674 or by sending a letter to Together With Tymlos Support Center, P.O. Box 5536, Louisville, KY 40255. I also understand that the Services may be revised, changed, or terminated at any time without any prior notification.

Communications: I authorize the Alliance to contact me by mail, telephone, or email, or, if I indicate my agreement and consent below, by text, with information about the Program, osteoporosis, and products; promotions, services, and research studies; and to ask my opinion about such information and topics, including market research and disease-related surveys.

Text Messaging Consent: I acknowledge that by checking the box for Text Messaging Consent below, I expressly consent to receive text messages from or on behalf of the Program at the mobile telephone number(s) that I provide. I confirm that I am the subscriber for the mobile telephone number(s) provided, and I agree to notify the Alliance promptly if any of my number(s) change in the future. I understand that I can opt out from future text messages at any time by texting STOP or UNAVAILABILE to 1-855-730-8591 from my mobile phone. I also understand that additional text messaging terms and conditions may be provided to me in the future as part of an opt-in confirmation text message. I understand that my consent is not required for my participation in the program from Radius Health, Inc. I understand standard text message and data rates may apply.

☐ **Send me text messages.** **Cell Phone:** _____

Patient Authorization to Use and Disclose Health Information

I authorize my healthcare providers and staff, my health insurer, health plan or programs that provide me healthcare benefits (together, "Health Insurers"), and any specialty pharmacies that dispense my medication to disclose to Radius Health, Inc., and their agents specified as the "Alliance," health information about me including information related to my medical condition and treatment, health insurance coverage and claims, prescription (including fill/refill information), and referral to and enrollment in the Program described as "My Information" for the purposes of enrolling me in and providing certain services, including:

- To determine if I am eligible to participate in the ***Together With Tymlos*** Patient Support Program coverage determination or other support programs
- To investigate my health insurance coverage for TYMLOS
- To obtain prior authorization for coverage
- To assist with appeals of denied claims for coverage
- For the operation and administration of the Program
- To refer me to, or to determine my eligibility for, other programs, foundations, or alternative sources of funding or coverage that may be available to provide assistance to me with the costs of my medication

I understand and agree that my healthcare providers, Health Insurers, and specialty pharmacy(ies) may receive remuneration from the Alliance in exchange for disclosing My Information to the Alliance and/or for providing me with support services in connection with the Program. Once My Information has been disclosed to the Alliance, I understand that federal privacy laws may no longer protect it from further disclosure. However, the Alliance agrees to protect My Information by using and disclosing it only for the purposes allowed by me in this Authorization, or as otherwise allowed by law. I understand that I do not have to sign this Authorization. A decision by me not to sign this Authorization will not affect my ability to obtain medical treatment, insurance coverage, access to health benefits, or Alliance medications. However, if I do not sign this Authorization, I understand that I will not be able to participate in the ***Together With Tymlos*** Patient Support Program. I understand that this Authorization shall remain in effect until my participation in the ***Together With Tymlos*** Patient Support Program ends unless and until I withdraw (take back) this Authorization before then. Further, I understand that I may withdraw this Authorization at any time by mailing Together With Tymlos Support Center, P.O. Box 5536, Louisville, KY 40255 or faxing 1-800-910-4610 a written request. Withdrawal of this Authorization will end my participation in the ***Together With Tymlos*** Patient Support Program and will not affect any disclosure of My Information based on this Authorization made before my request is received and processed by my healthcare providers and staff, my Health Insurers, and specialty pharmacies.

I authorize the ***Together With Tymlos*** Patient Support Program, Radius Health, Inc., their agents, and third-party contractors or their service providers authorized to administer the ***Together With Tymlos*** Patient Support Program to: (1) use the information that I provided on this form to determine my eligibility for, and assist with my continued participation in, the ***Together With Tymlos*** Patient Support Program, (2) use my Social Security Number for purposes of verifying my identity only, and (3) contact me to seek feedback on ***Together With Tymlos*** Patient Support Program services.

Patient's Name: _____

Patient's Signature: _____

Signature Date: _____

Phone: 1-866-TYMLOS4 | Fax: 1-800-910-4610

For Full Prescribing Information, including Boxed Warning, please see www.TYMLOSPI.com.