HOSPITAL TO HOME

Program Enrollment

ENROLL + PRESCRIBE

Patients must be enrolled to receive their free 30-day supply of medicine. Complete and fax both pages to **866-611-2110**. All fields are required unless noted as optional. Please note this form can also act as a prescription with the completion of Section 5. Otherwise, a valid prescription must be sent via one of the methods indicated in Section 4.

❶ Patient Information

Name of Patient

Shipping Address (No PO boxes)

City | State | ZIP

Date of Birth / / | Gender: Male | Female

Patient Phone

Complete the fields below or attach information to this form

Allergies ☐ None

Other Medications ☐ None

Health Conditions

❷ Enrolling Healthcare Professional Contact Information (For enrollment confirmation and questions)

Name of Enrolling Healthcare Professional

Institution Name

Phone

Fax

❸ Prescribed Medication (Check one)

- ☐ STIOLTO® RESPIMAT® (tiotropium bromide & olodaterol) Inhalation Spray
- ☐ SPIRIVA® RESPIMAT® (tiotropium bromide) Inhalation Spray, 2.5 mcg/actuation
- ☐ SPIRIVA® HANDIHALER® (tiotropium bromide inhalation powder)

❹ How Prescription Will Be Completed (Only a single 30-day supply of medication will be sent)

Choose the method you will use to provide patient's prescribing information

☐ With this enrollment form (Must complete Section 5) ☐ Fax **866-611-2110** ☐ Phone **844-416-9393**

☐ ePrescribe **Name:** Community Medical Center Pharmacy **Location:** San Diego, CA **NCPDP:** 5640289 **NPI:** 1821395609

❺ Prescription Information (Optional if Rx is sent separately)

Name of Prescribing Healthcare Professional | NPI/DEA #

Address | City | State | ZIP

Date of Order / / | Quantity | Refill | Dosing Instructions | Physician Signature

X

❻ Follow-Up Appointment HCP Contact Information (Optional)

Name of Follow-up Healthcare Professional | Phone

! To join the Hospital to Home Program, patient must review and select the specific program offerings, as well as read and sign the HIPAA Authorization on page 2. If you have any additional questions, please contact Hospital to Home Customer Service at **844-416-9393.**

HOSPITAL TO HOME

Program Enrollment

Hospital to Home Program Offerings

The Hospital to Home Program (the "Program") includes various offerings, including delivery of a 30-day free supply of medication, pharmacy support calls, and patient education. The Program is funded by Boehringer Ingelheim Pharmaceuticals, Inc. and its affiliates and subsidiaries (collectively, "BIPI") and is administered in conjunction with certain of its contractors and agents, such as mail-order pharmacies and clinical education contractors (collectively, the "Contractors").

Please select below the program offerings you would like to participate in (the "Selected Program Offerings") by checking the applicable boxes.

☐ **Delivery of 30-day Free Supply of Medication**

By checking here, I am authorizing BIPI and the applicable Contractors to use the information provided on this form to provide me with a delivery of a 30-day free supply of medication, as well as a kit of written materials to help me start and stay on my medication.

☐ **Pharmacy Support Phone Calls**

By checking here, I am authorizing BIPI and the applicable Contractors to provide me with pharmacy support phone calls. I understand and agree to be contacted at the phone number provided for the pharmacy support phone calls, and for a voicemail to be left if I am not available.

If at any time I change my mind regarding participating in the Selected Program Offerings, I understand that I can opt out by contacting Hospital to Home Customer Service at 844-416-9393.

HIPAA Authorization

I understand that the information contained on this form, including my medical and contact information, as well as any other information necessary for my participation in the Program (collectively, "Personal Information") may contain or otherwise be viewed as a form of "protected health information" as defined under the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations ("HIPAA").

By signing below, I am authorizing each of my health care providers, including my physicians, pharmacists, and hospitals (collectively, "Health Care Providers") to use and disclose my Personal Information to BIPI and the applicable Contractors for purposes of me receiving the Selected Program Offerings.

I understand that BIPI and the applicable Contractors will receive, use, and disclose my Personal Information to provide me with the Selected Program Offerings. I also understand that BIPI and the applicable Contractors may disclose my Personal Information back to my Health Care Providers.

I understand and agree that:

- Once my Personal Information has been disclosed to BIPI and the applicable Contractors, federal or state privacy laws may no longer protect the information from further disclosure.
- I do not have to sign this Authorization. Refusing to sign will not affect the treatment provided by my Health Care Providers in any way. However, I will not be eligible to receive the Selected Program Offerings.
- This Authorization will remain in effect until I am no longer participating in the Selected Program Offerings, at which time it will expire.
- I may cancel/revoke this Authorization at any time by contacting the Health Care Providers who assisted with my enrollment in the Program. If I cancel, my Health Care Providers cannot make further disclosures of my Personal Information, but the cancellation is not effective to the extent BIPI and the applicable Contractors, or other parties, have already acted in reliance on this Authorization.
- I am entitled to a copy of the Authorization.

X

_____

Patient/Personal Representative Signature Date

_____

Printed Name

_____

Relationship to Patient