Arna ASSIST ...Enhancing Life

Bronchitol®
(Mannitol) Inhalation Powder

Service Request and Prescription

Phone: 888-865-1222

Fax or mail this form to: **866-410-6241, ArnaAssist™**
Patient Assistance Program, PO Box 30317
Bethesda, MD 20824-0317

Prescriber Information

Name:

Credentials: Phone: Fax:

NPI Number:

State medical license#:

Institution:

Street Address:

City: Fax:

Patient Information

Name:

DOB:

Home Phone:

Cell Phone:

Caregiver/ Guardian name:

Relationship:

Home Phone: Cell Phone:

Street Address:

City: State: ZIP:

Primary insurance: ID# Group#:

Secondary insurance: ID# Group#:

Diagnosis code:

☐ SIG: Dose: 400 mg (one blister pack of 10 mannitol inhalation powder capsules BID)

Refills: Quantity : 28 day supply

Service Information

☐ Benefits investigation only

☐ I attest that this patient has passed the BRONCHITOL® (mannitol) inhalation powder Tolerance Test

☐ Enrolment in HUB and Prescription Fulfillment Assistance

Specialty Pharmacy Information—*Only complete if requesting Prescription Fulfillment Assistance above.*

Please check the box of the pharmacy to which you submitted this patient's prescription.

☐ CVS Specialty Pharmacy®

☐ Accredo®

☐ Maxor Specialty Pharmacy

☐ Walgreens®

☐ Northwell Health, Inc.

(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 Arna Pharma 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 Arna Pharma 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 Arna Pharma to stop processing my personal information, edit my personal information, or delete my personal information. To exercise these rights, I can contact Arna Pharma at 888 ARNA 144 or at Privacy.USA@Arnapharma.com.)

Prescribers signature: **Date:**

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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 Arna Pharma Inc., its subsidiaries, affiliates, representatives, agents and contractors ("ArnaAssist™") 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 Arna Pharma. I understand that my information disclosed under this authorization may be redisclosed by Arna Pharma 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 requesting such cancellation to ArnaAssist™, PO Box 30317, Bethesda, MD 20824-0137, 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 I withdraw my 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 ArnaAssist™, may revoke the permission to authorize pharmacy providers to use my Personal Health Information in communications 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 signature: _____ **Date:**

ArnaAssist™ may contact me by mail, telephone call, text message (including calls and text messages made with an automatic telephone dialing system or a pre-recorded 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 Arna Pharma may communicate with me via communication channels at the address and/or mobile telephone number previously provided by me to Arna Pharma and/or my healthcare provider. I understand that my consent to receive calls, mail, 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 text message, and there is no assurance of confidentiality for information communicated in this manner. I also understand that text messages have inherent privacy risks, especially when access to my mobile device is not password protected. I further understand that my text messages may be accessed by my employer, depending on the access I have provided to my employer. Nevertheless, I want Arna Pharma to communicate with me via communication channels as detailed herein. I understand that messages transmitted pursuant to this consent will be subject to Arna Pharma'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 a request to unsubscribe or by contacting ArnaAssist™ at 888-865-1222. For text messages, standard message and data rates may apply.

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 _____ **Date:**