tadliq® (Tadalafil) Oral Suspension 20 mg/5 mL

TADLIQ® PRESCRIPTION REQUEST FORM DIRECT TO CMP SUPPORT SERVICES (HUB)

Prescriber: Please complete all fields of the application, sign, and date.
Patient: Please read and sign the Patient Authorization on page 2.
Include the front/back copy of patient's insurance card, if available.
Fax the completed application to us at: 844-267-0020.

QUESTIONS?
Please Contact
CMP Support Services
Mon- Fri, 8am- 5pm EST
844-267-0001

PATIENT INFORMATION

First Name: | Last Name:

Gender: ◯ Male ◯ Female | DOB: (dd/mm/yyyy) | Preferred Language:

Street Address:

City: | State: | ZIP:

Home Phone:

Cell Phone:

Email:

Authorized Caregiver or Alternate Contact:

Relationship to Patient:

Alternate Contact Phone:

Alternate Contact Email:

INSURANCE INFORMATION

◯ Patient has **NO** insurance

Fax a copy of front and back of patient's medical and prescription benefit insurance cards or please complete the information below.

Medical/Health Insurance Name: | Phone:

Policy ID: | Group Number:

Policy Holder Name:

Policy Holder DOB: | Relationship to Patient:

Prescription Benefit Name: | Phone:

Policy ID: | Group #: | PCN #: | BIN #:

Policy Holder Name:

Policy Holder DOB: | Relationship to Patient:

Secondary Benefit Insurance Name: | Phone:

Group Number:

Secondary Insurance Policy Holder Name:

Secondary Policy Holder DOB: | Relationship to Patient:

READ AND SIGN PATIENT AUTHORIZATION ON PAGE 2

PRESCRIBER INFORMATION

Prescriber Name:

Prescriber Specialty:

Practice Name:

Prescriber Email:

Street Address:

City: | State: | ZIP:

Office Phone: | Office Fax:

MD NPI #: | Tax ID: | State License #:

Office Contact Name:

Office Contact Phone:

Office Contact Email:

DIAGNOSIS

Patient Diagnosis (ICD-10):

PRESCRIPTION INFORMATION & AUTHORIZATION

	Dose:	Quantity:	NDC #:	Refills:
◯ **Tadliq 20 mg/5mL**			**46287-045-15**	

Directions for Use:

I verify that the patient and healthcare provider information on this enrollment form was completed by me or at my direction and I have discussed with my patient and informed him/her of the Program enrollment. The information contained herein is complete and accurate to the best of my knowledge. I understand that I must comply with my practicing state's specific prescription requirements, such as e-prescribing, state-specific prescription form, fax language, etc. Noncompliance with state-specific requirements could result in outreach to me by the dispensing pharmacy.

By signing below I certify that: **1.** I am prescribing the TADLIQ medication for the patient identified in the Patient Information section. I certify that this prescription is medically necessary for the patient and that it will be used as directed. I certify that I will be supervising the patient's treatment and verify that the information provided is complete and accurate to the best of my knowledge. **2.** I have received the appropriate permission from the patient and met any other applicable requirements imposed under the Health Insurance Portability and Accountability Act of 1996 and applicable state laws needed to release the above information to CMP Pharma and its designated agents and service providers for the purposes of verifying the patient's insurance coverage for TADLIQ, confirming prior authorization requirements for TADLIQ, if needed, on my patient's behalf, providing information on appeals of denials of claims, coordinating delivery of TADLIQ and providing my patient with other education and support available through CMP Support Services associated with TADLIQ. **3.** I authorize the above prescription to be forwarded to the pharmacy chosen by the named patient. **4.** Contacting the patient with educational materials about the patient's prescription medication or to evaluate the effectiveness of CMP Support Services and/or the Patient Assistance Program.

Prescriber Signature: | Date:

Dispense as Written/Do Not Substitute

OR

Prescriber Signature: | Date:

Substitution Permitted

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PATIENT AUTHORIZATION

By signing below, I authorize my healthcare providers, including pharmacies that may receive my prescription for TADLIQ®, to disclose my personal health information ("PHI") as required to support my TADLIQ therapy, to CMP Pharma, its affiliates, and its agents in order to administer CMP Support Services on its behalf (collectively, CMP Pharma) including (1) enrolling me in CMP Support Services; (2) establish benefit eligibility and potential out-of-pocket costs for TADLIQ; (3) communicate with healthcare providers and health plans about treatment plans; (4) provide support services and financial assistance; (5) assist in getting TADLIQ shipped to me or my healthcare provider; and (6) facilitate participation in CMP Support Services offerings about which I have elected to receive information.

I authorize CMP Pharma and its agents to use my personal information via phone and/or email for the purposes listed above, as well as to contact me for reasons related to CMP Support Services, to obtain further information or clarification regarding any adverse event I may experience. I understand that once my PHI has been disclosed to CMP Pharma, it may no longer be protected by federal privacy law, however, CMP Pharma intends to use and disclose my PHI received pursuant to this authorization only for the purposes described above or as required by law. I understand the Pharmacy that is dispensing my medication may contact me to provide support services, for purposes of CMP Support Services as outlined in this authorization.

I understand that I can withdraw this authorization by calling CMP Support Services at 1-844-267-0001 or mailing a letter with my notice of revocation to **CMP Support Services, 680 Century Pt Suite 1000, Lake Mary FL 32746**. I understand that if I do revoke the authorization, it will thereafter be invalid, but that uses, and disclosures made in reliance on the authorization prior to its revocation will not be invalidated. I understand that I may refuse to sign this form and, if I do so, I will not be eligible to participate in CMP Support Services, but such refusal will not affect my eligibility to obtain medical treatment or insurance coverage. This authorization expires ten (10) years after the date I sign it below. I understand that I am entitled to receive a copy of this authorization.

☐ By checking this box, I agree to be contacted by text messages ("texts"), placed by CMP Pharma, its agents, or service providers (collectively, CMP Pharma) to the mobile phone number I have provided for the purpose of helping me optimize my therapy. I certify that the number I am providing belongs to me or my designated caregiver. I understand that I may opt out of receiving such messages by calling 1-844-267-0001 or replying "STOP" by text to any text from CMP Pharma, and that consent to being contacted by text messages is not a condition to participate in the CMP Support Services or to purchase any product or services.

Patient Name:	Patient DOB:
Parent/Authorized Representative Name:	Relationship to Patient:

Signature: Date:

CMP Support Services is here to help

CMP Support Services is here to support both physicians and patients with accessing Tadliq by assisting with the following:

- ✓Verifying benefits & securing insurance coverage for Tadliq.
- ✓Providing updates to the prescriber during each step of the process.
- ✓Identifying commercially eligible patients that may qualify for co-pay assistance.*
- ✓Submitting the prescription to the specialty pharmacy provider to dispense Tadliq.

Call toll-free (844) 267-0001

Mon-Friday 8am-5pm ET • Fax Number: (844) 267-0020

* Terms and conditions apply. Visit tadliq.com/hub for more program information.