Together With Tymlos (abaloparatide) injection
Support Center Patient Enrollment Form

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

- ☐ **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
- ☐ Copy of Insurance Card (Front and Back) Attached

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

1. Patient Information

Last Name: ______ First Name: ______

Street Address: ______

City: ______ State: ______ Zip: ______

Date of Birth: ______ Last 4 Digits SSN: ______

Gender ☐ Male ☐ Female

Primary Phone: ______ ☐ Cell ☐ Home

☐ Send me text messages (See Terms and Conditions on the back of this form.)

*Email Address: ______

Patient Is Uninsured ☐ Yes ☐ No Patient Received a Sample ☐ Yes ☐ No

2. Patient Medical Information

Patient Diagnosis ICD-10 Code:

☐ M81.______ (Postmenopausal osteoporosis without current pathological fracture)

☐ M80.______ (Postmenopausal osteoporosis with current pathological fracture)

Prior Postmenopausal Osteoporosis Therapy, Duration and Reason for Discontinuation (eg, switch, drug holiday, patient request, etc): ______

Pertinent Medical History and Concurrent Medications: ______

Allergies: ______ *DXA Score(s): ______

3. Patient Support Program

☐ **Sign me up for *Together With Tymlos*! 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, to provide me the services described below and those that may be added in the future. Such services may include:

- Coverage information
- Medication dispensing support
- ***Together With Tymlos*** Clinical Educator Network
  - Injection training
  - Medication and adherence communications
- Patient starter kits
- Savings offer, if eligible[†]
- Other online support, education, and assistance services

[†]If eligible, I understand that Savings information will be sent to my designated 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.

4. Patient Authorization

By signing here, I agree to terms and conditions on the next page.

Patient's Name: ______

Patient's Signature: ______

Signature Date: ______

5. Prescriber Information

Last Name: ______ First Name: ______

*Primary Specialty: ______ State License Number: ______

NPI Number: ______ *Group NPI Number: ______

Tax ID Number: ______

Practice Name: ______

Practice Street Address: ______

City: ______ State: ______ Zip: ______

Phone: ______ Fax: ______

Office Contact Name (Last, First): ______

Office Contact Email: ______

6. Prescription Information

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

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

Product Name: TYMLOS™ (abaloparatide) injection 80 mcg

Directions: Daily, subcutaneous 80 mcg injection

Dispense Quantity:

☐ Thirty (30) days

☐ Ninety (90) days

Ancillary Supplies:

☐ One hundred (100) day needle supply

☐ Sharps container

Refills:

☐ No Refills ☐ Refills (specify quantity): ______

7. 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.

The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

Prescriber Signature: ______

Date: ______

(No Stamps Accepted)

☐ Dispense as Written (No Substitution Permitted)

☐ Substitutions Allowed/Brand Exchange Permitted

Patient Consent Form for Patient to Read and Sign

Together With Tymlos (abaloparatide) injection Program Enrollment

Information Sharing: I further authorize Radius Health, Inc., and their agents, specified as 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.

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.

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.

Text Messaging Consent: I acknowledge that by checking the box for Text Messaging Consent on the front of this form, 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 UNAVAILABLE 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.

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.

This authorization will expire in ten (10) years from the date signed in the Patient Authorization section on page 1 of this Enrollment Form unless a shorter period is required by the law of my state residence.

TYMLOS®
(abaloparatide) injection

Together with Tymlos | Patient Support Program

INDICATION AND IMPORTANT SAFETY INFORMATION

WARNING: RISK OF OSTEOSARCOMA

- **Abaloparatide caused a dose-dependent increase in the incidence of osteosarcoma (a malignant bone tumor) in male and female rats. The effect was observed at systemic exposures to abaloparatide ranging from 4 to 28 times the exposure in humans receiving the 80 mcg dose. It is unknown if TYMLOS will cause osteosarcoma in humans.**
- **The use of TYMLOS is not recommended in patients at increased risk of osteosarcoma including those with Paget's disease of bone or unexplained elevations of alkaline phosphatase, open epiphyses, bone metastases or skeletal malignancies, hereditary disorders predisposing to osteosarcoma, or prior external beam or implant radiation therapy involving the skeleton.**
- **Cumulative use of TYMLOS and parathyroid hormone analogs (e.g., teriparatide) for more than 2 years during a patient's lifetime is not recommended.**

Orthostatic Hypotension: Orthostatic hypotension may occur with TYMLOS, typically within 4 hours of injection. Associated symptoms may include dizziness, palpitations, tachycardia or nausea, and may resolve by having the patient lie down. For the first several doses, TYMLOS should be administered where the patient can sit or lie down if necessary.

Hypercalcemia: TYMLOS may cause hypercalcemia. TYMLOS is not recommended in patients with pre-existing hypercalcemia or in patients who have an underlying hypercalcemic disorder, such as primary hyperparathyroidism, because of the possibility of exacerbating hypercalcemia.

Hypercalciuria and Urolithiasis: TYMLOS may cause hypercalciuria. It is unknown whether TYMLOS may exacerbate urolithiasis in patients with active or a history of urolithiasis. If active urolithiasis or pre-existing hypercalciuria is suspected, measurement of urinary calcium excretion should be considered.

Adverse Reactions: The most common adverse reactions (incidence ≥2%) are hypercalciuria, dizziness, nausea, headache, palpitations, fatigue, upper abdominal pain and vertigo.

INDICATIONS AND USAGE

TYMLOS is indicated for the treatment of postmenopausal women with osteoporosis at high risk for fracture defined as a history of osteoporotic fracture, multiple risk factors for fracture, or patients who have failed or are intolerant to other available osteoporosis therapy. In postmenopausal women with osteoporosis, TYMLOS reduces the risk of vertebral fractures and nonvertebral fractures.

Limitations of Use

Because of the unknown relevance of the rodent osteosarcoma findings to humans, cumulative use of TYMLOS and parathyroid hormone analogs (e.g., teriparatide) for more than 2 years during a patient's lifetime is not recommended.

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

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

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