MannKind Cares

MannKind Cares Enrollment Form for Afrezza®

afrezza (insulin human) Inhalation Powder

For questions, please call MannKind Cares at (844)-323-7399

1 Required Patient Information

Patient's Name (first, MI, last) Sex: ☐ Male ☐ Female Date of Birth (mm/dd/yyyy)

Cell Phone Home Phone

Street Address

City State Zip code

E-mail

2 Required Pharmacy Benefit Insurance Information

Please complete all fields below, **or** include a copy of the patient's pharmacy insurance card(s) [front and back]. ☐ Copy of insurance card(s) attached

Policyholder Name ID#

Prescription Insurance Name Phone #

Rx Group # Rx BIN # Rx PCN #

Secondary Insurance ID#

Rx Group # Rx BIN # Rx PCN #

3 Required Diagnosis & Medical Necessity

Primary Diagnosis (Select IDC-10) ☐ E10 Type 1 ☐ E11 Type 2 ☐ Other_____

A1C before starting Afrezza _____% _____Date (mm/dd/yyyy)

Patient Information (check all that apply): ☐ **Chart Notes Attached (Required)**

☐ has been a non-smoker for at least 6 months

☐ does not have chronic lung disease, such as asthma or COPD

☐ has completed a baseline FEV1 test with a baseline value of: _____

☐ (If Type 1): is being prescribed Afrezza in combination with a long-acting insulin

☐ has experienced an inadequate treatment response, contraindication, or intolerance/tolerance to OAD (oral antidiabetic) medication

☐ is non-compliant with injected rapid-acting insulin therapy due to inability or unwillingness to inject or intensify therapy

☐ has hypertrophy, needle phobia, neuropathy, arthritis, or other physical or mental impairments to prevent successful injections

☐ has experienced an inadequate treatment response, contraindication, or intolerance/tolerance to rapid-acting insulin

☐ has used rapid-acting insulin therapy within the last 3 months without achieving goal, or with unacceptable post-prandial hyper- or hypo-glycemia

Other Clinical Information (including any known allergies):_____

4 Required Prescriber Information

Prescriber Name

NPI # Tax ID #

Practice Name

Street Address

City State Zip code

Office Contact Name Phone #

E-mail

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5 Required — Prescription Information

Dispense Afrezza® (insulin human) Inhalation Powder as follows:

Note: Refer to Afrezza Dosing & Titration Guide if needed

1. Choose Pack (select only one NDC):

☐ **4 Unit Cartridges**	Includes 360 Total Afrezza Insulin Units	NDC 47918-874-90
☐ **8 Unit Cartridges**	Includes 720 Total Afrezza Insulin Units	NDC 47918-878-90
☐ **12 Unit Cartridges**	Includes 1080 Total Afrezza Insulin Units	NDC 47918-891-90
☐ **4 & 8 Units Titration Pack**	Includes 1080 Total Afrezza Insulin Units	NDC 47918-880-18
☐ **4, 8 & 12 Units Titration Pack**	Includes 1440 Total Afrezza Insulin Units	NDC 47918-902-18
☐ **8 & 12 Units Titration Pack**	Includes 1800 Total Afrezza Insulin Units	NDC 47918-898-18

Quantity (# of packs):_____ # of Refills: _____ Day Supply: ☐30 ☐60 ☐90 ☐Other_____days

2. Directions for use

Inhale _____ units per meal Use additional ____ units as needed Total Daily Units_____

6 Optional — Afrezza Start-Out Program*

Dispense Afrezza® (insulin human) Inhalation Powder as follows:

Note: Refer to Afrezza Dosing & Titration Guide if needed

1. Choose Pack (select only one NDC):

☐ **4 Unit Cartridges**	Includes 360 Total Afrezza Insulin Units	NDC 47918-874-90
☐ **8 Unit Cartridges**	Includes 720 Total Afrezza Insulin Units	NDC 47918-878-90
☐ **12 Unit Cartridges**	Includes 1080 Total Afrezza Insulin Units	NDC 47918-891-90
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☐ **8 & 12 Units Titration Pack**	Includes 1800 Total Afrezza Insulin Units	NDC 47918-898-18

Quantity (# of packs):_____ # of Refills: _____

2. Directions for use

Inhale _____ units per meal Use additional ____ units as needed Total Daily Units_____

**Program provides patients with free drug while coverage is being pursued. Medicare/Medicaid insured patients are eligible for up to 2 months; commercially insured patients are eligible for up to 12 months.*

STOP — Prescriber Certification

X_____

Physician Signature Date (mm/dd/yyyy)

By my signature above, I attest that I believe that this prescription complies with my state's prescribing laws, and that I have obtained from my patient all required authorization to release all patient health and other personal information, including, but not limited to, the information on this form, to MannKind Corporation and its agents and representatives (collectively, "MannKind") MannKind may use and further disclose patient information to healthcare providers, pharmacies, insurance companies, prescription drug plans, and other third-party payers (collectively, "Third Parties") to facilitate the filling of prescription for and the delivery and administration of Afrezza [insulin human] Inhalation Powder, assist patient in obtaining insurance coverage for Afrezza, contact patient by mail, email, and/or telephone to enroll in, and administer, programs that provide Afrezza support services, provide patient with free educational information and materials, conduct surveys to measure patient satisfaction with Afrezza and Afrezza support services, and contact patient about participating in clinical trials and market research. My patient understands that once his/her information is disclosed, it may no longer be protected by federal privacy laws (the Health Insurance Portability and Accountability Act) or state privacy laws and may be further disclosed to others. However, my patient understands that MannKind will not release his/her information to any party, except as provided in this authorization or as permitted by applicable law, without first obtaining his/her (or an authorized representative's) separate written consent. My patient understands that he/she may refuse to give this authorization and such refusal will not affect his/her ability to receive Afrezza, but it will limit his/her ability to receive support services for Afrezza. I verify that the information being disclosed in this access/ enrollment form is complete and accurate to the best of my knowledge. I understand that ASPN Pharmacies, LLC (ASPN) and MannKind reserve the right at any time and for any reason, without notice, to modify this access/enrollment form or to modify or discontinue any services or assistance provided through this Program. Finally, I authorize ASPN and MannKind as my designated agents to use and disclose my patient's protected health information as may be necessary for treatment, payment, and healthcare operations, including to verify the accuracy of any information provided, to verify patient eligibility, to provide for payment and reimbursement, and to forward the above prescription information, by fax or other mode of delivery, to a pharmacy for fulfillment.

☐ Send status updates via email

You may opt in to receive emails from ASPN and MannKind regarding the status of your patient's prescription. By agreeing to receive emails from ASPN and MannKind, you acknowledge that ASPN and MannKind will send standard email to you via the internet. Therefore, there is potential for these unencrypted emails to be intercepted by third parties, if you share your email account or computer with others, those parties may be able to access your confidential information. You should notify ASPN and MannKind immediately if you wish to cease receiving emails or if your email address changes. You should not use emails for emergencies.

Fax Completed Form and Chart Notes to MannKind Cares at (800) 561-6174

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