

Please call toll-free (844) 3-AFREZZA with any questions. Fax to: (800) 561-6174



AFREZZA® Access Form



New Start

Continuing/Restart Treatment

Adherence Call

Patient Teach Only

Patient (First and Last Name): _____ Date of Birth: _____ Male Female

Preferred Contact Number: Home Work Cell _____ Best time of day to be contacted: Morning Afternoon Evening _____ Allergies: _____

Address _____ City: _____ State: _____ Zip: _____

MannKind develops educational and marketing materials for AFREZZA® patients. Do we have your permission to send these materials to you? Yes No Email: _____

INSURANCE INFORMATION (Please complete all fields below, or attach copy front and back of insurance card.)

Insurance Name: _____ Policyholder Name: _____ Relationship to Patient: _____ Pharmacy Help Desk #: _____

Member ID #: _____ Rx BIN #: _____ PCN #: _____ Rx Group #: _____

Special Instructions/Supplemental Insurance: _____

DIAGNOSIS AND MEDICAL NECESSITY

Diabetes Mellitus Type 1 Type 2 _____ HbA1c ≥ 7% Yes No

Has patient been a non-smoker for at least 6 months? Yes No Does patient have chronic lung disease, such as asthma or COPD? Yes No Has patient completed a baseline FEV₁ test? Yes No

Has patient received or is receiving AFREZZA®? Yes No Is patient receiving basal insulin via an insulin pump? Yes No If yes, what is the insulin product being used? _____

Is adult patient being prescribed AFREZZA® for Type 1 diabetes mellitus in combination with a long-acting basal insulin? Yes No

Has patient experienced an inadequate treatment response, contraindication, or intolerance or tolerance to OAD (oral antidiabetic) medication? Yes No

Is patient non-compliant with injected rapid-acting insulin therapy due to inability or unwillingness to inject or intensify therapy? Yes No

Has patient used rapid-acting insulin therapy within the last 3 months without achieving goal OR with unacceptable postprandial hypoglycemia? Yes No

Additional supporting documentation attached: Lab Results Treatment History Baseline FEV₁ Value: _____ Other Clinical Information

Rx DIRECTIONS FOR USE

Meal 1: _____ Units* Meal 2: _____ Units* Meal 3: _____ Units* Other _____ Units* Total Daily _____ Units* Total Monthly _____ Units* Refills _____ *AFREZZA® is administered in 4-unit increments

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

<input type="checkbox"/> 180 Cartridges	90 – 4-unit cartridges and 90 – 8-unit cartridges and 2 inhalers (Titration Pack)	NDC 47918-880-18
<input type="checkbox"/> 180 Cartridges	60 – 4 unit cartridges, 60 – 8 unit cartridges, 60 – 12 unit cartridges and 2 inhalers (Titration Pack)	NDC 47918-902-18
<input type="checkbox"/> 90 Cartridges	90 – 4-unit cartridges and 2 inhalers	NDC 47918-874-90
<input type="checkbox"/> 90 Cartridges	60 – 4-unit cartridges and 30 – 8-unit cartridges and 2 inhalers	NDC 47918-884-63
<input type="checkbox"/> 90 Cartridges	30 – 4-unit cartridges and 60 – 8-unit cartridges and 2 inhalers	NDC 47918-882-36
<input type="checkbox"/> 90 Cartridges	60 – 8-unit cartridges and 30 – 12-unit cartridges and 2 inhalers	NDC 47918-894-63

Request Start Out Program: Yes No **Afrezza Titration Pack (NDC 47918-880-18)** **Patient Teach:** Public Location of Choice At Work FaceTime® Skype®

For commercially insured patients only (Not available for Medicare, Medicaid, or other federal or state healthcare programs) **1 Pack, Use as directed by physician, 2 refills (Only filled through a MannKind Cares Pharmacy).**

COMPLETE THE FOLLOWING

Physician Name: _____ Street Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ NPI #: _____

COMPLETE THE FOLLOWING (optional)

Preferred Pharmacy: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____

By my signature below, I attest 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.

Please send me status updates via email. You may opt in to receive emails from ASPN and MKC regarding the status of your patient's prescription. By agreeing to receive emails from ASPN and MKC, you acknowledge that ASPN and MKC will send standard emails to you via the Internet. Therefore, there is potential for these unencrypted emails to be intercepted by unauthorized 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 MKC immediately if you wish to cease receiving emails or if your email address changes. You should not use emails for emergencies.

(Physician Signature): _____ Date: _____

FORM SUBMISSION OPTIONS



Secure Provider Portal
www.mannkindcares.com



Fax
(800) 561-6174



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Patient Authorization

Patient (First and Last Name): _____
Address: _____ City: _____ State: _____ Zip Code: _____
Home # (required): _____ Cell #: _____ Work #: _____ Other Alternate #: _____
Email: _____ DOB: / /

AUTHORIZATION TO USE AND DISCLOSE HEALTH AND OTHER PERSONAL INFORMATION

I authorize my physician and his/her staff to disclose my 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") so that MannKind may use and further disclose my information to healthcare providers, pharmacies, insurance companies, prescription drug plans and other third-party payers (collectively, "Third Parties") in order to:

- 1. facilitate the filling of prescription for and the delivery and administration of AFREZZA® [insulin human] Inhalation Powder;
2. assist me in obtaining insurance coverage for AFREZZA®;
3. contact me by mail, email, text, and/or telephone to enroll me in, and administer, programs that provide AFREZZA® support services;
4. provide me with free educational information and materials;
5. provide me with product training performed by a MannKind representative, patient advocate, or clinical educator;
6. conduct surveys to measure my satisfaction with AFREZZA® and AFREZZA® support services; and
7. contact me about participating in clinical trials and market research.

I further authorize the Third Parties to disclose health and other personal information about me in their possession to MannKind in order to assist MannKind in accomplishing the purposes described above. I understand that once my information is disclosed pursuant to this authorization, 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, I understand that MannKind will not release my information to any party, except as provided in this authorization or as permitted by applicable law, without first obtaining my (or my authorized representative's) separate written consent. I understand that I may refuse to sign this authorization and such refusal will not affect my ability to receive AFREZZA®, but it will limit my ability to receive support services for AFREZZA®.

I understand that this authorization will remain in effect for ten years from the date of my signature, unless I revoke it earlier by contacting MannKind. If I revoke this authorization, MannKind will stop using and disclosing my information as soon as possible, but the revocation will not affect prior use or disclosure of my information in reliance on this authorization. I understand that the services provided by MannKind that are described in this authorization can be changed at any time, without prior notification. I understand that certain Third Parties may receive compensation in exchange for their disclosure of my information to MannKind. I also understand that I have the right to receive a copy of this authorization.

Patient name (please print): _____
Signature of patient (or personal representative): _____ Date: _____
Authority/relationship of personal representative (if applicable): _____

MannKind Contact (if applicable)
Print Name: _____
For Afrezza® Clinical Educator Use Only¹
Patient has attended a product training session
Clinical Educators MannKind Representative/Agent
Patient Advocates

¹ MannKind or its Agents will only text you with your permission. Standard text message and data rates apply.