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

MannKind Cares℠

AFREZZA® Access Form

afrezza (insulin human) Inhalation Powder

☐ New Start ☐ Continuing/Restart Treatment

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 NECCESSITY

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 FEV_1 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 FEV_1 Value:_____ ☐Other Clinical Information:_____

Rx DIRECTIONS FOR USE

Meal 1: _____ Units* Meal 2: _____ Units* Meal 3: _____ Units* Other_____ Units* Total Daily 0 ____Units* Total Monthly 0 ____Units* Refills _____ *AFREZZA® is administered in 4-unit increments

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

☐ 180 Cartridges	90 – 4-unit cartridges and 90 – 8-unit cartridges and 2 inhalers (Titration Pack)	NDC 47918-880-18
☐ 180 Cartridges	60 – 4 unit cartridges, 60 – 8 unit cartridges, 60 – 12 unit cartridges and 2 inhalers (Titration Pack)	NDC 47918-902-18
☐ 90 Cartridges	90 – 4-unit cartridges and 2 inhalers	NDC 47918-874-90
☐ 90 Cartridges	90 – 8-unit cartridges and 2 inhalers	NDC 47918-878-90
☐ 90 Cartridges	90 – 12-unit cartridges and 2 inhalers	NDC 47918-891-90

Request Start Out Program: ☐Yes ☐No
(For commercially insured patients Only. Not available for Medicare, Medicaid, or other federal or state healthcare programs). Only filled through a MannKind Cares Pharmacy.

☐ Afrezza Titration Pack (NDC 47918-880-18) 1 Pack, Use as directed by physician, 2 refills
☐ Afrezza Titration Pack (NDC 47918-902-18) 1 Pack, Use as directed by physician, 2 refills

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