SYNERA® (lidocaine and tetracaine) Topical Patch Trial Request Form

The SYNERA Trial Program provides eligible patients* with 2 free SYNERA patches.

Instructions for Patients:

- Complete the patient information section on the next page and bring it to your healthcare professional.
- Ask your healthcare professional to complete the prescriber information and trial authorization sections of the form.
- The SYNERA trial patches will be sent to the address indicated by your healthcare professional.
- Expect a follow-up call from a Customer Service representative from The Alliance Pharmacy, the administrator of the program.

Instructions for the Prescriber:

- Complete the appropriate information to authorize the product trial.
- Provide instructions for use.
- Sign and date prescription authorization.
- Complete prescriber information and check the box to indicate the desired shipping address.
- Fax completed form to 1-888-747-9329.

Please complete and have your healthcare professional fax the form on the next page.

GALEN
Advancing Human Health

*Eligible patients are those who have not previously participated in this program and have not previously filled a prescription for SYNERA.

 PMR-JUN-2015-0190 June 2015

SYNERA®
(lidocaine and tetracaine) Topical Patch

SNAP…The SYNERA NOW Access Program

SYNERA®
(lidocaine and tetracaine) Topical Patch

TRIAL REQUEST FORM

PATIENT INFORMATION

NAME: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

PHONE #: _____ **DATE OF BIRTH:** _____ **LAST FOUR DIGITS OF SOCIAL SECURITY #:** _____
(USED FOR INSURANCE VERIFICATION PURPOSES ONLY)

E-MAIL: _____

LIST ANY DRUG ALLERGIES HERE: _____

Patient Enrollment Authorization

I understand that The Alliance Pharmacy ("TAP") is a licensed pharmacy. I hereby authorize any insurer, public or private, hospital, physician or other healthcare provider to disclose to TAP, and its agents, all medical, financial, and insurance information, and other personal identifying information (collectively, "Personal Information") for the purpose of my participation in The SYNERA Now Access Program (the "Program"). I also authorize TAP and its agents to disclose Personal Information to Galen (US) Inc. ("Galen") and/or a nominee of Galen and any person or entity listed above for the Purpose hereinafter defined. With respect to the disclosure of Personal Information, I understand that TAP will disclose only the minimum amount necessary to accomplish the Purpose.

I understand that certain Personal Information may be used by TAP and Galen and/or Galen's nominee on behalf of Galen (as applicable) for the purposes of my participation in the Program, to contact me for marketing purposes, to provide health and product information, to see if I would like to participate in product research activities and such Personal Information may be matched with my prescription data for the purpose of evaluating future improvements to the Program (altogether referred to as the "Purpose"). TAP, Galen and/or Galen's nominee understand that information about my health is personal and are committed to protecting the privacy of my Personal Information in accordance with all applicable federal, state, national and local data protection laws.

By submitting this form, I am consenting to the use of my Personal Information for the Purpose. I also understand that any information that reveals my identity will not be used for any purpose other than the Purpose described above, unless I give written consent.

This authorization will expire upon termination of my enrollment in the Program. I understand that I have the right to revoke my authorization at any time by writing to or calling the Program at (866) 767-4883. I have read, understand, and agree to all of the above.

_____ _____ _____ _____

Patient Signature ***Date*** ***Parent or Guardian Signature (required if under 18)*** ***Date***

TRIAL AUTHORIZATION

PRESCRIBER: PLEASE COMPLETE THE APPROPRIATE INFORMATION .

DRUG		INSTRUCTIONS	QTY	REFILLS
SYNERA (lidocaine and tetracaine) Topical Patch	**PRODUCT TRIAL** ☐		2 Patches	Not Allowed

I hereby verify that I have not previously prescribed SYNERA for the patient listed above. I attest that the product requested through the Trial Program, will not be exported or transferred in exchange for money, other property or services. No portion of the trial product will be submitted for reimbursement purposes through Medicaid/Medicare or any other third-party insurance plan.

_____ _____

Prescriber Signature ***Date***

PRESCRIBER INFORMATION

NAME: _____

NPI#: _____ **PRESCRIBER E-MAIL:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

PHONE #: _____ **FAX #:** _____

SYNERA trial patches will be shipped directly to the address of choice as indicated below:
Please ship to (select one): Patient address ☐ Prescriber address ☐

☐ I would like a Galen representative to contact me

FAX COMPLETED FORM TO THE ALLIANCE PHARMACY AT: 1-888-747-9329

CUSTOMER SERVICE #: 866-767-4883