

Patient

Patient Name: Date of Birth: Gender:  
Address: City: State: Zip:  
Telephone: Preferred Language:  
Patient Representative: Representative Phone (if different):

*In lieu of filling out the insurance section, attach a copy (front & back) of the patient's insurance and prescription cards.*

Primary Insurance

**Primary Insurance Provider:** NPI#: Contact Name:  
Address: Unit#: City: State: Zip:  
Telephone: Fax:  
**Prescription/Drug Card Company:** Phone:  
Rx BIN #: Group #: Member ID #:

Secondary Insurance

**Secondary Insurance Provider:** NPI#: Contact Name:  
Address: Unit#: City: State: Zip:  
Telephone: Fax:  
**Prescription/Drug Card Company:** Phone:  
RxBIN #: Group #: Member ID #:

Prescription

**Dose:**                      **Qty:**                      **Frequency:**  
**Dosage: Minor units/kg:**                      **Moderate units/kg:**                      **Major units/kg:**  
**Prophylaxis:** Dispense      doses      x/week for a duration of      months  
**Episodic:** Dispense                      doses for minor/                      doses for moderate/                      doses for major  
Prescriber Name:                      Office Contact:  
Address:                      City:                      State:                      Zip:  
Telephone:                      Fax:                      Tax ID #:                      NPI #:

**PROGRAM REQUIREMENTS:**

1. The SMART START Program for ADYNOVATE® [Antihemophilic Factor (Recombinant), PEGylated] provides ADYNOVATE for up to 12 months while the patient and HCP actively pursue commercial insurance coverage (exhaust all appeals or are approved) whichever comes first.
2. To be eligible, patients must have commercial insurance with a valid prescription with denial or delay of coverage confirmed by the Hematology Support Center.

**PRESCRIBER INSTRUCTIONS:**

1. Complete this enrollment form.
2. Sign the authorization and release below.
3. Fax the completed form to Shire's Hematology Support Center (HSC) at (866) 467-7740.

ADYNOVATE provided under the SMART START Program cannot be exported or transferred in exchange for money, other property, or services. No portion of ADYNOVATE provided under the SMART START Program will be submitted for reimbursement to any third-party payer, including Medicare, Medicaid, or any third-party program, either directly or indirectly. The prescription is valid for SMART START Program. The patient must obtain a new prescription for ADYNOVATE for future use.

**PHYSICIAN/PRESCRIBER AUTHORIZATION AND RELEASE (REQUIRED)**

I hereby authorize the agents of Shire to use the above information to process interim drug to my patient. I have obtained consent from this patient to release this information to the mail order pharmacy and the program call center (the agents). I understand that the agents of Shire will keep this information confidential and will use it only for the SMART START Program for ADYNOVATE. This usage might include a follow-up survey about the patient's experience and my experience with the SMART START Program and ADYNOVATE. ADYNOVATE provided through the SMART START Program will not be exported or transferred in exchange for money, other property, or services. No portion of ADYNOVATE provided under the SMART START Program will be submitted for reimbursement to any third-party payer, including Medicare, Medicaid, or any third-party program, either directly or indirectly. The prescription is valid for SMART START Program. The patient must obtain a new prescription for ADYNOVATE for future use.

**PRESCRIBER SIGNATURE (REQUIRED):**

DATE: \_\_\_\_\_

**For more information, call Shire's Hematology Support Center at (855) 229-7377**