

Authorization to disclose health information

I agree to permit my health care provider (doctor's name) _____ ("Provider"), to disclose to Amgen & Wyeth, marketers of Enbrel® (etanercept) & their contractors, including Covance & McKesson (together, "Company"), information about me & my medical condition as is reasonably necessary to: (i) obtain information on insurance coverage & payment for ENBREL & identify potential patient assistance programs for me; (ii) assess the quality of reimbursement & patient assistance services provided to me; & (iii) share my information with my health insurers or other potential payors, if any, & with specialty pharmacies that can assist me in obtaining ENBREL. All of these parties may respond by disclosing information about me, my medical condition, & my insurance coverage to Company for the same purposes, which Company may share with my Provider. Company also may use my information to: (i) respond to my requests; (ii) perform data analysis to better understand my disease & the health care professionals who treat me; (iii) determine my eligibility for patient support services; & (iv) evaluate, or ask for my opinion on, the services, programs, & materials provided to me. In the future, Company may contact me with information about programs or services offered through 1-888-4ENBREL or on other topics I may find useful. I agree to permit Company to contact me to facilitate the services specified above. I authorize Company to use my information to enroll me & to facilitate my participation in the 1-888-4ENBREL patient support program (*Enliven® Services*). I understand that, as part of the program, Company may, from time to time, use my information to contact me by phone or mail with helpful information about ENBREL and my medical condition. Once my health information has been disclosed by my Provider, health insurers/payors, & specialty pharmacies, if any, to Company, federal privacy laws may no longer protect the information from further disclosure. However, Company agrees to protect my information by using and disclosing it only for the purposes described above or as permitted by law. My health information will not be used or disclosed by Company for any other purpose unless permitted by law or unless information that identifies me is first removed. These limitations continue even after this Authorization expires (ends) or I revoke (take back) this Authorization. I understand that I don't have to sign this Authorization, but if I don't, Company may not be able to perform any of the services listed above. My Provider, health insurers, & specialty pharmacies won't condition my medical treatment, payment for treatment, or insurance benefits on my signing of this Authorization. However, if I don't sign this Authorization, I may have to pay for ENBREL myself. I may revoke this Authorization at any time by sending a letter of revocation to Enbrel® (etanercept) Reimbursement Services, PO Box 2973, Phoenix, AZ 85062-2973. If I revoke this Authorization, however, Company may be unable to provide me with the services listed above. Revoking this Authorization will prevent my Provider, health insurers, & specialty pharmacies from making further disclosures of my health information for these purposes to Company after the date my letter of revocation is received & processed by them. However, revoking this Authorization will not affect Company's ability to use & disclose any information it has already received. I am entitled to a copy of this Authorization. This Authorization expires 10 years from the date of my signature.

Patient's Name (Print)

Address

City, State, ZIP

Daytime Phone Number

Patient's E-mail Address

Signature of Patient or Legal Representative

Date

X

Physician's Name (Print)

Physician's Phone Number

Please Fax to: 1-877-474-3867 or mail to:

Enbrel® (etanercept) Reimbursement Services
PO Box 2973
Phoenix, AZ 85062-2973

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