

Informed Consent
Lupron Depot (leuprolide acetate for depot suspension) Patient Support Program

PATIENT'S NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK/CELL/OTHER PHONE: _____

Birth date ___/___/___, sex: M / F (circle)

PATIENT'S PHYSICIAN: _____

PHYSICIAN TELEPHONE: _____ OFFICE CONTACT: _____

MEDICATION: _____ DOSAGE: _____ FREQUENCY: _____

I hereby grant permission to **ScriptAssist** and its licensed nurses to contact me directly in support of my treatment with Lupron Depot (leuprolide acetate for depot suspension) that my physician has prescribed for me. The best times to contact me are:

- Early Mornings (7-9); Weekdays 9-5; Weekday Evenings (5-8)

at the following phone number: _(____)_____.

The *ScriptAssist* nurse may leave a message identifying herself or himself by mentioning your doctor's name. Please check here if you do not want us to leave a message for you:

I authorize my physician or pharmacy to release the information requested on this consent form to *ScriptAssist*, in order to facilitate my participation in the support program.

I further authorize *ScriptAssist* to provide feedback to my physician or pharmacy on calls completed as part of the support program.

I understand that I can revoke this authorization at any time by giving notice to my physician, my pharmacy, or *ScriptAssist*, and that it expires automatically three years from the date signed.

I understand the following statements as they relate to this authorization.

1. I understand this authorization is voluntary and that I do not have to participate in this support program to receive my health care.
2. I understand that there is **no cost** to me for participation in this Program.
3. I understand my doctor will not receive any financial or in-kind compensation in exchange for referring me to this program.
4. I understand that the manufacturer of Lupron Depot (leuprolide acetate for depot suspension) will pay *ScriptAssist* for my participation in this program.
5. I understand that I may request a copy of information provided by my physician or pharmacy to *ScriptAssist* or by *ScriptAssist* to my physician or pharmacy, as such information relates to my participation in this program.
6. I understand that I may retain a copy of this Consent Form after I have signed it.
7. I understand that I may request a copy of this Consent Form.
8. I understand that *ScriptAssist* will not release my name or any other personally identifiable information to anyone other than my physician or pharmacy.

Signature of patient (or legal representative)

Date

Mail or FAX this form to: *ScriptAssist*, 7711 Carondelet Avenue, St. Louis MO 63105
FAX: (314) 863-8296 Toll-Free Telephone: (877) 835-2875