Patient Enrollment Form
The FOCUS™ Program for Onsolis™

As the *prescriber* of Onsolis™, I acknowledge that:

1. This patient being prescribed Onsolis™ is opioid tolerant: patients considered opioid tolerant are those who are regularly taking at least: 60 mg oral morphine/day, 25 mcg transdermal fentanyl/hour, 30 mg oral oxycodone/day, 8 mg oral hydromorphone/day, 25 mg oral oxymorphone/day, or an equianalgesic dose of another opioid for one week or longer.
2. This patient has been using around-the-clock opioid analgesia for at least one week.
3. This patient or a legally authorized representative has been counseled about the risks and benefits and appropriate use of Onsolis™, and about the risk of overdose due to giving Onsolis™ to someone for whom it has not been prescribed as described in the Medication Guide for Onsolis™.
4. I have provided and reviewed the Medication Guide for Onsolis™ with this patient or a legally authorized representative.

Prescriber Signature ____________________ Date ____________________

Prescriber Name, Credentials ____________________

DEA Registration Number ____________________ Prescriber Fax Number ____________________

As the *patient* being prescribed Onsolis™, or a legally authorized representative, I acknowledge that:

1. My prescriber gave me a copy of the Medication Guide for Onsolis™ and reviewed it with me. I have asked my prescriber all the questions I have about Onsolis™. I will ask my prescriber if I have any additional questions in the future about the use of Onsolis™.
2. I understand that there can be serious risks, especially if I do not take Onsolis™ as directed.
3. I understand that I must be regularly using another opioid ("narcotic") pain medicine for my constant pain. This is important because my body must become used to opioid medicine before I can take Onsolis™ (I am "opioid tolerant").
4. I agree that I will never give Onsolis™ to anyone else, even if they have the same symptoms, since it may harm them or even cause death.
5. I will store Onsolis™ in a safe place away from children because accidental use by a child is a medical emergency and can result in death.
6. I have reviewed the Patient Authorization for Disclosure and Use of Health Information Statement and I agree to its terms and conditions to authorize my healthcare providers and health plans to disclose my personal and medical information to Meda Pharmaceuticals Inc. (licensee) and their agents and contractors.

Patient Signature/Date ____________________

Patient Name (Last) ____________________

Patient Name (First) ____________________

☐☐/☐☐
Birthday (Month and Day)

Zip Code (5 Digits) ____________________

Personal Representative Signature/Date ____________________

☐Spouse ☐Legal Guardian

☐Designated Representative per Power of Attorney

Personal Representative Name (Printed) ____________________

Telephone Number Where You or Your Legally Authorized Representative Can Be Reached ____________________

Time of Day to Call: ☐Morning ☐Afternoon ☐Evening

Fax a completed, signed copy of this enrollment form to the FOCUS™ Program for Onsolis™ at **1-800-558-6302.**

For more information about Onsolis™, please see full prescribing information, including boxed warnings.

08/09 MDABEMV92833e

Onsolis™ fentanyl buccal soluble film CII

Patient Authorization for Disclosure and Use of Health Information Statement

The FOCUS™ Program for Onsolis™

By my signature on the Onsolis™ Patient Enrollment Form, I thereby authorize each of my physicians, pharmacists, and other healthcare providers (my "Providers") and each of my health insurers (my "Insurers") to disclose my personally identifiable health information, including my medical diagnosis, condition, and treatment (including prescription information), my health insurance, and my name, address, and telephone number (my "Health Information") to Meda Pharmaceuticals Inc. (Meda; licensee), their agents and representatives, including third parties authorized by Meda to administer the FOCUS™ Program for the following purposes:

1. Enroll me in the FOCUS™ Program, administer my participation in the program (including contacting me), evaluate the safety of Onsolis™ and the effectiveness of the program, provide me with educational information on the FOCUS™ Program and my medical condition, and enroll me in appropriate assistance programs;
2. Contact my Providers regarding shipment and receipt of Onsolis™;
3. Contact my Providers to collect, enter, and maintain my Health Information in a database;
4. Submit information to government agencies and other authorities, such as the FDA, regarding such matters as adverse events and the FOCUS™ Program;
5. Contact my Insurers as needed to verify my insurance coverage, review reimbursement issues, and assist with adjudication of claims;
6. Further use and disclosure of my Health Information as required or permitted by applicable law; and
7. Use or disclosure of my de-identified Health Information (all personal identifiable information has been removed) as permitted by applicable law.

I understand that federal privacy laws may no longer protect my Health Information after its disclosure to Meda and that it may be subject to re-disclosure. However, Meda agrees to protect my Health Information by using and disclosing it only for the purposes described.

I understand that I am not required to sign this Authorization. If I do not sign, I may not enroll in the FOCUS™ Program to receive Onsolis™ and may not receive the other services described above. Otherwise, my treatment, payment for treatment, insurance enrollment, or eligibility for insurance benefits will not be directly affected if I do not sign this Authorization.

I understand that I may revoke (withdraw) this Authorization at any time by sending a signed, written request to the FOCUS™ Program by:

- Fax: 1-800-558-6302, or
- Mail: PO Box 52024
  Phoenix, AZ 85072.

Meda shall notify my Providers and Insurers of my revocation, who may no longer disclose my Health Information to Meda once they have received and processed that notice. However, revoking this Authorization will not affect Meda's ability to use and disclose my Health Information that it has already received to the extent permitted under applicable law. If I revoke this Authorization, I may no longer participate in the FOCUS™ Program to receive Onsolis™ and the other services described above.

This Authorization expires ten (10) years from the date that I enroll in the FOCUS™ Program.

I understand and agree with the terms and conditions of this Authorization. I also understand that I will receive a copy of this Authorization.

MEDA PHARMACEUTICALS