Rosiglitazone REMS Program

FOR V.A. USE ONLY

V.A. Patient Enrollment Form (Please Print) *indicates required fields

First Name:**_____ **MI:**___Last Name:**_____ ***DOB** (MM/DD/YY)**:**_____

This Patient Enrollment Form must be completed by you and your doctor or healthcare provider before you can receive a rosiglitazone medicine. Rosiglitazone medicines are available only through the **Rosiglitazone Risk Evaluation and Mitigation Strategy (REMS) Program**. This program was previously called the Avandia-Rosiglitazone Medicines Access Program®. You will not be able to get your medicine at your local pharmacy. You will receive your medicine by mail.

Rosiglitazone medicines include:

- Avandia® (rosiglitazone maleate)
- Avandamet® (rosiglitazone maleate and metformin hydrochloride)
- Avandaryl® (rosiglitazone maleate and glimepiride)
- Approved generic equivalents of these products

Patient Agreement

By signing this form, I agree that:

- I have read and talked with my doctor or healthcare provider about the risk information in the Medication Guide for the rosiglitazone medicine prescribed for me.
- I understand the risk information that my doctor or healthcare provider has talked about with me, including that these medicines may increase my risk of having a heart attack. My doctor has talked to me about the risks associated with alternative medicines containing pioglitazone (ACTOS®), which has not been shown to be associated with an increased risk of having a heart attack.
- I have had enough time with my doctor or healthcare provider before signing this form to ask him or her questions and talk about any concerns I have about rosiglitazone medicines or my diabetes treatment.
- I understand that to get a rosiglitazone medicine, I have to enroll in the Rosiglitazone REMS Program
- I understand that the Rosiglitazone REMS Program may contact me by phone, mail or email for more information about my taking part in the Rosiglitazone REMS Program.
- I give permission to my doctor, pharmacists, and any other healthcare providers (together “my Providers”) participating in the Rosiglitazone REMS Program and to the REMS Program Coordinating Center to share my personally identifiable health information, including prescription information, and my name, address, telephone number (together my “Protected Health Information”) for the purposes of enrolling me into the Rosiglitazone REMS Program, filling my prescriptions and managing the Rosiglitazone REMS Program.
- I understand that all information collected on the enrollment form will be stored in a secure database maintained by the Rosiglitazone REMS Program Coordinating Center.

After joining the program, if you do not get your first prescription within about two weeks, call your health care provider or the Rosiglitazone REMS Program at 1-800-282-6342.

***Patient/Guardian Signature:**_____ ***Date** (MM/DD/YY)**:**_____
Printed Name of Guardian:_____

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Patient Information
***First Name:** _____ **MI:** _____ ***Last Name:**_____
***Date of Birth** (MM/DD/YY):_____ ***Gender:** □ **Female** □ **Male**
***Address 1:**_____
Address 2:_____
***City:** _____ ***State:** _____ ***ZIP Code:**_____
***Preferred Phone:** _____**Alternate Phone:** _____
Email: _____

***Is the patient:** □ **new to rosiglitazone therapy** □ **continuing rosiglitazone therapy**
***Is this patient:** □ **Outpatient** □ **Long-term Care** □ **Hospitalized**

VA PATIENT—INSURANCE NOT REQUIRED

Prescriber Information
***First Name:** _____ **MI:**_____ ***Last Name:**_____
***National Provider Identification (NPI) Number:** _____
or

***State License Number:**_____ ***State of Issue:**_____
***Name of VA Facility:** _____
Phone Number:**_____Fax Number:**_____

Prescription Information (to be completed by your doctor or other healthcare provider):

Prescription:

□ **rosiglitazone maleate / Avandia** _____ (Strength (mg)) _____ (Quantity)

□ **rosiglitazone maleate/metformin hydrochloride / Avandamet** _____ (Strength (mg)) _____ (Quantity)

□ **rosiglitazone maleate/glimepiride / Avandaryl** _____ (Strength (mg)) _____ (Quantity)

□ **Brand medically necessary** _____
To ensure brand name dispensing, please check box and initial in the space provided

Provide Dosing Instructions: _____
Number of refills: _____

Shipping Information

***Ship to:** □ **Patient Home (address listed above)** □ **V.A. Pharmacy (address listed below—all fields required)**
VA Facility Name: _____
Address: _____
V.A. Pharmacy Contact:_____

City: _____State:_____ Zip Code: _____
Phone: _____ Pharmacy Secure Fax Number:_____

By signing this form, I acknowledge that I have discussed the risk information with this patient. I have documented in his/her medical record that this patient meets the eligibility criteria for enrollment into the Rosiglitazone REMS Program.

***Prescriber Signature:_____ *Date** (MM/DD/YY)**:**_____
Printed Name of Prescriber:_____

Please have the pharmacy fax the completed form to 1-888-772-9404 and provide a copy of this form to the patient.

Phone: 1-800-282-6342 **FAX: 1-888-772-9404** **www.rosiglitazonerems.com**