Enrollment Form

Door to Door
Your Brand On Demand

Flomax® (tamsulosin HCl) capsules Program Enrollment Form

IMPORTANT: Please complete all 3 sections in their entirety

❑ I will mail my prescription

- Write your date of birth on the original copy of your prescription
- Mail completed Enrollment Form with your original FLOMAX prescription to:
  Door to Door c/o Eagle Pharmacy
  PO Box 90937
  Lakeland, FL 33804
- Allow 5-9 days for delivery following receipt of Enrollment Form

❑ My doctor will submit my prescription

- See instructions on back
- Entire form must still be completed by patient

You can also enroll by calling 1-855-799-6835 or visiting FlomaxDoorToDoor.com

1. Patient Information

Name _____
First Middle initial Last

Date of birth (mm/dd/yyyy) _____/_____/_____ Gender ❑ Male ❑ Female

Shipping address_____

City_____ State_____ ZIP_____

Primary phone number (_____)_____ Email_____

Additional Information

Do you have any drug allergies?
❑ No ❑ Yes If yes, please list

_____

_____

Are you taking other medications?
❑ No ❑ Yes If yes, please list (include over-the-counter, herbal, vitamins, etc.)

_____

_____

Please list any health conditions:

_____

2. Prescription Refill Selection (You must choose a refill amount.)

Your first 30-day supply is FREE with your enrollment.*

❑ One-month supply for $35* ❑ Three-month supply for $90 — just $1 a day*

3. Please Check the Boxes Below

❑ Yes! I allow Boehringer Ingelheim Pharmaceuticals, Inc. and companies working on its behalf to use this information to contact me about health- and product-related information and services associated with FLOMAX and other products. Boehringer Ingelheim Pharmaceuticals, Inc. respects your privacy.

❑ I understand that Eagle Pharmacy will be contacting me to obtain my credit card information for payment before the product will be shipped. **THIS BOX MUST BE CHECKED IN ORDER TO RECEIVE YOUR MEDICATION.**

❑ This program offers brand name medications, and as such, I elect to receive branded product. No generic substitutions will be made. **THIS BOX MUST BE CHECKED IN ORDER TO RECEIVE YOUR MEDICATION.**

❑ Yes, I want to take advantage of having future prescription refills shipped to me automatically. I understand that my refills will be shipped to the shipping address and billed to the credit card on file. Enrollment in the auto refill program is optional and preferences can be updated at any time through the Eagle Pharmacy Patient Portal or by calling 1-855-799-6835. Orders that have already shipped cannot be returned for a refund.

***See Terms and Conditions on the next page.**

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***Terms and Conditions:** Patients must have a valid prescription for Flomax® (tamsulosin HCl) capsules.

By enrolling, I elect to receive the branded product and acknowledge that no generic substitution will be offered (if applicable). Should I wish to receive a generic product in the future, I will call 1-855-799-6835 to opt out of this program.

Patients have a choice of two payment structures: 1) Patients can enroll for a one-month supply at $35 for 30 capsules of FLOMAX, or 2) Patients can enroll for a three-month supply at $90 for 90 capsules of FLOMAX. All patients, upon initial enrollment, will receive an additional free one-month supply (30 capsules) of FLOMAX. Enrollment includes the fee payment for the initial prescription.

If you have Medicare Part D, Medicaid, or a similar state or federally funded medical assistance program, you will pay a cash price of $35 for a one-month supply, or $90 for a three-month supply of FLOMAX. All Medicare Part D orders are processed without the use of insurance and cannot be applied to Part D true out-of-pocket (TrOOP) costs. State and local taxes may apply.

Boehringer Ingelheim Pharmaceuticals, Inc. retains the right to rescind, revoke, or amend this offer at any time without notice.

❑ My doctor will submit my prescription

(**Sections 1-3** must still be completed in their entirety by the patient.)

By fax:

- Complete this Enrollment Form and have your doctor sign it
- Have your doctor fax the completed form to: 1-855-284-0572

By mail:

- Physician: mail completed Enrollment Form with patient's original prescription to Eagle Pharmacy (see address on the previous page)

ePrescribing:

- Physician: ePrescribe in your system to Eagle Pharmacy
  Name: Eagle Pharmacy
  Location: Lakeland, FL
  NPI #: 1487905840
  NCPDP #: 5711975

Healthcare Provider Information

(To be completed by the healthcare provider.)

Full name _____

NPI #_____ Phone _____

Physician fax number _____

Prescription information

Drug name: FLOMAX

Strength _____ Days' supply _____

Number of refills _____

Date written _____

Directions _____

Physician signature _____

Boehringer Ingelheim

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