Enroll Your Patients in the BOSULIF Trial Prescription Program

To begin, please have each eligible patient complete parts 1 to 5 of this enrollment form. The remaining sections must be completed by a healthcare professional. This program is intended for patients new to BOSULIF® (bosutinib). All products will be sent by the BOSULIF Trial Prescription Program Administrator.

Fax this completed form along with the Patient Authorization form to **1-855-578-1686**. Fax must be sent from a healthcare provider's office. You may also mail this form along with the Patient Authroization form to the **BOSULIF Trial Prescription Program Administrator, TrialCard, 14001 Weston Parkway, Suite 103, Cary, NC 27513**. Valid through December 31, 2014.

Parts 1-5: Patient Information

1. Name ..... (First) (Middle) (Last)
2. Date of birth .....
3. Address ..... (Street) (Suite/Floor) (City) (State) (ZIP Code)

(Please note that product cannot be shipped to PO boxes)

Daytime telephone number ..... Evening telephone number .....

4. ☐ Yes, I would like to opt in to receive voicemails from TrialCard, the administrator of the BOSULIF prescription program, to inquire about my experience taking BOSULIF during the free trial period.

5. I, ... (Print Name), certify that I am not currently receiving BOSULIF therapy.

Signature of patient/guardian ..... Date .....

If guardian, please state relationship to patient ..... (Print Relationship)

Parts 6-11: Physician Information

6. Name ..... (First) (Middle) (Last)
7. Professional designation license # (required by law) .....
8. Business Address ..... (Street) (Suite/Floor) (City) (State) (ZIP Code)
9. Business telephone number ..... 10. Fax number .....
11. E-mail address .....

Parts 12-15: BOSULIF Free Trial Prescription 30-Day Supply

12. Please note whether patient has any allergies and/or is taking concomitant medications.

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13. Dosage Strength—quantity to dispense

☐ 500 mg tablets x 30 ☐ 100 mg tablets x ..... To be determined by physician in accordance with prescribing information requirements for BOSULIF

14. Directions for use .....

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15. Signature of requesting licensed physician

I acknowledge that any patient selected for this program is not currently receiving therapy with BOSULIF and has not been previously enrolled in the BOSULIF Trial Prescription Program.

..... (Signature of Physician) (Date of Request)

For questions about the BOSULIF Trial Prescription Program, please call 1-855-541-5929, Monday–Friday 9:00 AM–5:00 PM (EST).

Pfizer

Bosulif® bosutinib 500 mg tablets