IncyteCARES | Jakafi® ruxolitinib (tablets) 5mg • 10mg • 15mg • 20mg • 25mg

IncyteCARES for Jakafi Program Enrollment Form

Please legibly complete all fields not marked optional, for timely processing. **Fax completed form to 1-855-525-7207.**
We will contact you within 2 business days. For questions, call **1-855-452-5234.**

*For details about all program services your patient can receive upon enrollment, see **HCP.IncyteCARES.com/Jakafi**.*

☐ **Check here to request only a Benefits Investigation for your patient.**

PATIENT INFORMATION

Full Name _____ Date of Birth ____/____/____

Home Address _____

City _____ State _____ ZIP _____

Medicare ID *(Required for patients with Medicare)* _____ Email *(Optional)* _____

Phone Number _____ Alternate Phone Number *(Optional)* _____

Best Time to Call *(Optional)* ☐ Morning ☐ Afternoon ☐ Evening

Primary Language *(Optional)* ☐ English ☐ Spanish ☐ Other _____

Is patient a resident of the United States or Puerto Rico? ☐ Yes ☐ No

ALTERNATE (CAREGIVER) CONTACT *(Optional)*

Full Name _____ Relationship _____ Phone Number _____

FINANCIAL INFORMATION *(Optional)*—Required only to apply for the Patient Assistance Program.
See ***HCP.IncyteCARES.com/Jakafi*** for details.

Current Annual Household Income _____ Number of People in Household _____

INSURANCE INFORMATION

☐ **Patient does not have medical insurance.**

Primary Insurer _____ **Type of insurance:** ☐ Commercial ☐ Government ☐ Other

Policy ID Number _____ Group Number _____

Phone _____ *If patient is the policy subscriber, check here and skip fields below.* ☐

Subscriber Name _____ Subscriber Date of Birth ____/____/____

Secondary Insurer *(if applicable)* _____ Phone _____

Policy ID Number _____ Group Number _____

*If patient is **not** the policy subscriber, check here and complete fields below.* ☐

Subscriber Name _____ Subscriber Date of Birth ____/____/____

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Please see Full Prescribing Information for Jakafi® (ruxolitinib) at Jakafi.com.

IncyteCARES

PRESCRIPTION FOR JAKAFI® (ruxolitinib)

Use this section to write your patient's prescription.

A separate prescription form is not needed, unless required by state law. Date ____ /____ /____

Patient Name _____ Date of Birth ____/____/____

Medication Name: Jakafi® (ruxolitinib) Dosage: ☐ 5 mg ☐ 10 mg ☐ 15 mg ☐ 20 mg ☐ 25 mg

Directions _____

Concurrent Medications ☐ None _____

Allergies *(Optional)* ☐ None _____

Dispense (quantity) ____ Refill(s) ____ DEA Number _____

Ship medication to: ☐ Patient's Home ☐ Doctor's Office

Preferred Specialty Pharmacy *(Optional)* _____

Prescriber Signature _____ Date ____/____/____

PRESCRIBER INFORMATION

Prescriber Full Name _____

Collaborative Physician Name *(If applicable)* _____

State License Number _____ Payer-Specific ID Number _____

Tax ID Number _____ NPI Number _____

Site/Facility Name _____

Street Address _____ City _____ State ____ ZIP _____

Office Contact Name _____ Email *(Optional)* _____

Phone Number _____ Fax Number _____

CLINICAL INFORMATION

Indication for which you are prescribing Jakafi® (ruxolitinib) for this patient:

☐ Intermediate or high-risk myelofibrosis (MF), including primary MF, post–polycythemia vera MF, and post–essential thrombocythemia MF in adults

☐ Polycythemia vera (PV) in adults who have had an inadequate response to or are intolerant of hydroxyurea

☐ Steroid-refractory acute graft-versus-host disease (aGVHD) in adult and pediatric patients 12 years and older

☐ Chronic graft-versus-host disease (cGVHD) after failure of one or two lines of systemic therapy in adult and pediatric patients 12 years and older

☐ Other (include description and diagnosis code) _____

Treatment status: ☐ New to Jakafi ☐ Currently on Jakafi ☐ Restarting Jakafi

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HIPAA AUTHORIZATION

I authorize my healthcare providers (eg, physicians, pharmacies) and my insurance company to disclose personal health information about me, including information related to my medical condition and treatment, my health insurance coverage, and my address, email address, and telephone number (collectively, my "PHI") to Incyte, its agents, and the IncyteCARES for Jakafi program (collectively, "Incyte") so that Incyte may use the information for purposes of: (i) assisting in my enrollment in IncyteCARES for Jakafi; (ii) assessing my eligibility for out-of-pocket cost assistance or free drug or referring me to other programs or sources of funding and financial support; (iii) coordinating delivery of Jakafi® (ruxolitinib) to me or my healthcare provider; (iv) providing education, information on Incyte products and services, and ongoing support services to me related to Jakafi; (v) gathering feedback on my therapy and/or disease state; (vi) contacting me by mail, email, phone, or fax for any of the above purposes; and (vii) creating information that does not identify me personally for use for other purposes related to Jakafi. I understand that my pharmacy providers may receive remuneration for making such disclosures. I also authorize my healthcare providers and my insurance company to use my PHI to communicate with me about Incyte products and services and I understand that they may receive remuneration for making such communications. I understand that, once disclosed pursuant to this authorization, my PHI may no longer be protected under federal or state law and could be disclosed by Incyte to others, but I understand that Incyte will make reasonable efforts to keep it private and to disclose it only for the purposes set forth in this authorization.

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All fields are required unless noted.

I understand that I have a right to receive a copy of this authorization. This authorization expires one year after the date below unless I cancel it before then. To review Incyte's Privacy Policy, please visit **incyte.com/privacy-policy**.

☐ **I consent** ☐ **I do not consent**

Printed Name of Patient	Printed Name of Legal Guardian (if applicable)
Signature of Patient (or legal guardian)	Dated (MM/DD/YY)

By signing above, I am indicating that I am legally authorized to consent and that I am providing my consent as the patient or the patient's legal guardian for Incyte to collect, process and disclose my health data I provide for the purposes described within the consent above.

PATIENT OPT-IN FOR ONGOING EDUCATION AND SUPPORT

All fields are required unless noted.

I consent to Incyte collecting, using and disclosing my health data for the following purposes:

- To enroll me and manage my participation in Incyte's IncyteCARES program, which includes activities related to my condition or treatment (for example, co-pay card programs, payer medication coverage verification, nurse educator support, disease management support), and to manage Incyte's products, services, and programs related to my condition or treatment.

Incyte uses the following when it administers the Incyte IncyteCARES program:

- Health data—my name (and the name of my caregiver if applicable), gender, date of birth, contact information and information relating to my health condition or treatment.

I understand that my consent to this use of my health data is required for me to participate in the Incyte IncyteCARES program. I also understand that Incyte will not sell my health data to third parties, but Incyte may disclose my health data to

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Incyte's vendors only for Incyte's business purposes related to the Incyte IncyteCARES program. I understand that Incyte may use my health data to contact me by mail, email, or telephone, for the above purposes. I also understand that if I do not consent to the use of my health data for the above purposes, I will not be able to participate in the program. Finally, I understand that I may withdraw my consent to processing my health data for the above purposes at any time by calling 1-855-446-2983 or visiting **incyte.com/privacy-policy** and that if I withdraw my consent, I will no longer be able to participate in the program. I understand that this consent will remain in effect for one year.

By signing the consent to use, I agree that these entities may use my health information to administer the program or as permitted or required by applicable privacy laws. I permit such use for one year after the dates I sign the consent, unless and until I revoke it in writing prior to that time.

☐ **I consent** ☐ **I do not consent**

Printed Name of Patient	Printed Name of Legal Guardian (if applicable)
Signature of Patient (or legal guardian)	Dated (MM/DD/YY)

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