



# IncyteCARES Program Enrollment Form

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Please legibly complete all fields not marked optional, for timely processing. **Fax completed form to 1-855-525-7207.**

We will contact you within 3 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](http://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](http://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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For complete program details, visit [HCP.IncyteCARES.com/JAKAFI](http://HCP.IncyteCARES.com/JAKAFI).

**Please see Full Prescribing Information for JAKAFI XR™ (ruxolitinib) at JAKAFI.com.**



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**PRESCRIPTION FOR JAKAFI XR™ (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 XR™ (ruxolitinib)**

Dosage (once daily):  11 mg  22 mg  33 mg  44 mg  55 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 \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**If your patient is not covered for JAKAFI XR™ (ruxolitinib), we can check to see if they are covered for twice-daily JAKAFI® (ruxolitinib) instead. If they are covered, we will contact you for a new prescription.**

**Check here to opt out of this Benefits Investigation.**

**PRESCRIBER INFORMATION**

Prescriber Full Name \_\_\_\_\_

Office Contact Name \_\_\_\_\_ Email (Optional) \_\_\_\_\_

Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

State License Number \_\_\_\_\_ Payer-Specific ID Number \_\_\_\_\_

Tax ID Number \_\_\_\_\_ NPI Number \_\_\_\_\_

Site/Facility Name \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ ZIP \_\_\_\_\_

Collaborative Physician Name (If applicable) \_\_\_\_\_

**CLINICAL INFORMATION**

Indication for which you are prescribing JAKAFI XR™ (ruxolitinib) for this patient:

- Myelofibrosis (MF)** D75.81
- Acute Graft-Versus-Host Disease (GVHD)** D89.810
- Acute or Chronic GVHD** D89.812
- Other** (include description and diagnosis code) \_\_\_\_\_
- Polycythemia Vera (PV)** D45
- Chronic GVHD** D89.811
- GVHD, Unspecified** D89.813

Treatment status:  New to JAKAFI XR  Currently on JAKAFI XR  Restarting JAKAFI XR

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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 program (collectively, “Incyte”) so that Incyte may use the information for purposes of: (i) assisting in my enrollment in IncyteCARES; (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 XR™ (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 XR; (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 XR. 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](https://www.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.

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## **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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