IncyteCARES | MONJUVI® tafasitamab-cxix | 200mg for injection, for intravenous use

IncyteCARES 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 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/MONJUVI**.*

☐ **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 CONTACT *(Optional)*

Full Name _____ Relationship _____ Phone _____

INSURANCE INFORMATION

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

Please attach a copy of Insurance Card(s) (front and back).

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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PRESCRIPTION FOR MONJUVI® (tafasitamab-cxix)

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 ____ /____ /____ Patient Weight (kg) _____

Dosing _____ mg per dose (Recommended dose: 12 mg/kg)

Medication Name: MONJUVI® (tafasitamab-cxix)

Directions: 12 mg/kg of actual body weight administered as an intravenous infusion.

☐ Adult patient with relapsed or refractory diffuse large B-cell lymphoma (DLBCL) not otherwise specified, including DLBCL arising from low grade lymphoma, and who are not eligible for autologous stem cell transplant (ASCT).

- ☐ **Prescription 1/Cycle 1**—5 doses per each 28-day cycle. Administer on Days 1, 4, 8, 15, and 22. 0 refills.
- ☐ **Prescription 2/Cycles 2 and 3**—4 doses per each 28-day cycle. Administer on Days 1, 8, 15, and 22. 1 refill.
- ☐ **Prescription 3/Cycle 4+**—2 doses per each 28-day cycle. Administer on Days 1 and 15. _____ refills.

☐ Adults with relapsed or refractory follicular lymphoma (FL)

- ☐ **Prescription 1/Cycles 1 to 3**—4 doses per each 28-day cycle. Administer on Days 1, 8, 15, and 22. 2 refills.
- ☐ **Prescription 2/Cycles 4 to 12**—2 doses per each 28-day cycle. Administer on Days 1 and 15. 8 refills.

☐ Other Indication _____

Patient Diagnosis (Primary ICD-10-CM Code) _____

Previous Therapy Given

Dates _____ Dose _____

Therapy Given _____ Frequency _____

Concurrent Medications *(Optional)* ☐ None _____

Allergies *(Optional)* ☐ None _____

Prescriber Signature _____ DEA Number *(Optional)* _____

PRESCRIBER INFORMATION

Prescriber Full Name _____ 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 _____

Site of Infusion *(If different from above)* _____

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For complete program details, visit ***HCP.IncyteCARES.com/MONJUVI***.
Please see the Full Prescribing Information for MONJUVI at MONJUVI.com.

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FINANCIAL INFORMATION *(Optional)*—Required only to apply for the Patient Assistance Program.

See ***HCP.IncyteCARES.com/MONJUVI*** for details.

Current Annual Household Income _____ Number of People in Household _____

HIPAA AUTHORIZATION

I authorize my healthcare providers (eg, physicians, pharmacies) and my insurance company to disclose and re-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 MONJUVI® (tafasitamab-cxix) to me or my healthcare provider; (iv) providing education, information on Incyte products and services, and ongoing support services to me related to MONJUVI; (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 MONJUVI. 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 if applicable)

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

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.

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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 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 date 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 if applicable)	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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