IncyteCARES | Pemazyre (pemigatinib) tablets 13.5mg·9mg·4.5mg

IncyteCARES for PEMAZYRE Form

Please legibly complete all fields not marked optional, for timely processing. **Fax completed form to 1-888-714-0016**.
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/PEMAZYRE**.*

☐ **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 a Puerto Rico? ☐ Yes ☐ No

ALTERNATE CONTACT *(Optional)*

Full Name _____ Relationship _____ Phone Number _____

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

Current Annual Household Income _____ Number of People in Household _____

INSURANCE INFORMATION

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

Type of insurance: ☐ Commercial ☐ Government ☐ Other

Primary Prescription Insurer _____

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 Prescription Insurer *(Optional)* _____ 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 ____ /____ /____

PRESCRIPTION FOR PEMAZYRE

Use this section to write your patient's prescription. (No Patient Authorization signature is required.)

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

Patient Name _____ Date of Birth ____/____/____

Allergies *(Optional)* ☐ None _____

Concurrent Medications *(Optional)* ☐ None _____

Medication Name: PEMAZYRE® (pemigatinib) tablets Dosage: ☐ 4.5 mg ☐ 9 mg ☐ 13.5 mg

Directions _____

Quantity _____ Days Supply _____ Refill(s) _____

Prescriber Signature _____ Date ____/____/____

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

PRESCRIBER INFORMATION

Prescriber Full Name _____

Please provide at least one of the following:

State License Number _____ Payer-Specific ID Number _____

Tax ID Number _____ NPI Number _____

Site/Facility Name *(Optional)* _____

Street Address _____ City _____ State ____ ZIP _____

Office Contact Name _____ Email *(Optional)* _____

Phone Number _____ Fax Number _____

CLINICAL INFORMATION

Indication for which you are prescribing PEMAZYRE® (pemigatinib) tablets for this patient:

☐ Previously treated, unresectable locally advanced or metastatic cholangiocarcinoma with a fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement as detected by an FDA-approved test.

☐ Relapsed or refractory myeloid/lymphoid neoplasms (MLNs) with FGFR1 rearrangement.

☐ Other (include description and diagnosis code) _____

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

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HIPAA AUTHORIZATION

I authorize my Healthcare Professionals (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 PEMAZYRE program (collectively, "Incyte") so that Incyte may use the information for purposes of: (i) 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; (ii) coordinating delivery of PEMAZYRE® (pemigatinib) to me or my Healthcare Professional; (iii) providing education, information on Incyte products and services, and ongoing support services to me related to PEMAZYRE; (iv) gathering feedback on my therapy and/or disease state; (v) contacting me by mail, email, phone, or fax for any of the above purposes; and (vi) creating information that does not identify me personally for use for other legitimate purposes. I understand that my pharmacy providers may receive remuneration for making such disclosures. I also authorize my Healthcare Professionals 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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IncyteCARES

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)

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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